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ROYAL COMMISSION ON MATTERS OF HEALTH AND SAFETY
ARISING FROM THE USE OF ASBESTOS IN ONTARIO

CHAIRMAN: J. STEFAN DUPRE, Ph.D.

COMMISSIONERS: FRASER J. MUSTARD, M.D.
ROBERT UFFEN, Ph.D., P.Eng., F.R.S.C.

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APPEARANCES:

Mr. N. McCombie	Injured Workers Consultants
Mr. D. Starkman	Asbestos Victims of Ontario
Mr. M. Edwards	Government of Ontario

180 Dundas Street
Toronto, Ontario
Tuesday,
July 20, 1982
VOLUME 53



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ROYAL COMMISSION ON MATTERS OF HEALTH AND SAFETY

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VOLUME 53

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THE FURTHER PROCEEDINGS IN THIS INQUIRY
RESUMED PURSUANT TO ADJOURNMENT

APPEARANCES AS HERETOFORE NOTED

DR. DUPRE: May we come to order, please?

This morning the Commission warmly welcomes Dr.
W.J. McCracken, executive director of the medical services
division, Workmen's Compensation Board.

Miss Kahn, would you swear in the witness, please?

DR. WILLIAM JOHN MCCRACKEN, SWORN

EXAMINATION-IN-CHIEF BY MR. LASKIN

Q. Dr. McCracken, could you briefly trace for us
your professional education and qualifications?

A. Yes.

I am a graduate in medicine, University of Toronto,
in 1945, and following my graduation and when I finished my term
in the armed forces - Royal Canadian Armed Medical Corps - I
elected to do postgraduate work in surgery, and I took my post-
graduate training in surgery in the...what was known as the Gallie
Course, named after the late Professor Gallie, and then took my
training in Toronto in the various hospitals in Toronto.

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graduate training in surgery in the...what was known as the Gallie
Course, named after the late Professor Gallie, and then took my
training in Toronto in the various hospitals in Toronto.

5 A. (cont'd.) Before entering into the Gallie Course, I was engaged in a research program with the department of pharmacology, University of Toronto, and at that time I developed a piece of equipment known as an oximeter, which was used to measure the level of oxygen or oxyhemoglobin, in blood, and we utilized that in studies of the effects of oxygen depletion in people undergoing removal of their lung for various lung diseases.

10 I obtained my Bachelor of Science degree on the basis of my thesis on that subject, and then when I completed my postgraduate training in surgery, including orthopedic surgery, plastic surgery, general surgery, I wrote and obtained my fellowship to the Royal College of Surgeons of Canada degree in general surgery, and I also obtained my Master of Surgery degree from the University of Toronto, based upon a thesis which I had developed at that time, and I subsequently obtained my degree as fellow of the American College of Surgeons, from the American College of Surgeons in the United States.

15 Following completion of my training, I spent one year with the Workmen's Compensation Board in the capacity of a surgical consultant, although at that time we did a general type of work, so I did general medical evaluation of claims at that time, as well as the surgical aspects, and also was involved in the assessment of permanent impairment or permanent disability in cases.

20 Q. When was that, Dr. McCracken?

A. That was following the completion of my training, which would be 1950/51.

25 I then left the Board and established myself in private or referred practice of surgery in Hamilton, where I practiced my specialty for twenty-one years, and in 1974, mid-1974, I elected to take employment with the Workmen's Compensation

30

5 A. (cont'd.) Board, and following coming to the Board in January of 1975, I was requested to assume the responsibility of the executive director of what was then known as the rehabilitation services division.

10 This division, the correct name or full name should have been, I suppose, the medical services and vocational rehabilitation services division, but it was too long a name, so they shortened it down. But I had the responsibility of directing the vocational rehabilitation aspect of the Board operations at that time as well.

Q. As well as the straight medical services?

A. As well as the medical services.

15 The vocational rehabilitation aspect, I was firmly convinced was extremely important to the Board operations, and it was built up accordingly and reached the point where it was separated away several years ago as a separate division.

Q. And that's the one now headed by Mr. Darnbrough?

A. That is correct.

20 Q. Did you have any involvement with the Workmen's Compensation Board between 1951 and 1974, when you were in practice?

A. Well, for the initial several years the Board would call upon me not infrequently to evaluate the more difficult, complex type of cases, and pass my opinion on the cases.

25 Most of those were in the field of traumatology, of course, and then following that my involvement with the Board was the same as any other surgeon in practice - namely the care of injured workers that were referred to me, and again, of course, that was in the field of traumatology.

30 Q. I take it in terms of your present position as executive director, the chain of responsibility - at least in the area we are particularly concerned with - is through Dr. Dowd, who is the medical director, director of the medical branch?

A. That's right.

Q. It's he who reports to you, and in turn Dr. Stewart
5 and Dr. Dyer report to Dr. Dowd?

A. That's correct.

Yes, the division...that's one of the branches of
the division is the medical branch.

Q. Yes.

10 Just for your own information, when Mr. John
McDonald was here and one of our witnesses last week, he was
good enough to provide us with an organization chart of the
medical services division, so we all have that firmly in front
of us.

A. Fine.

15 Q. Can I just understand what role and responsibility
you have in relation to the asbestos-related disease claims, and
in terms, first of all, of the claims for asbestosis, do you have
any direct involvement in the processing of those claims, in
making any recommendations, in consulting with the medical services
staff?

20 A. Very infrequently. My actual relationship to
the actual claim file for cases of asbestosis and other diseases
related to asbestos, claim by claim, is on occasion Dr. Dyer or
Dr. Stewart will briefly discuss some medical aspect of a case
with me and ask me what my thoughts might be on the subject, or
25 from time to time will show me an x-ray film and ask me what I
think of it, although bearing in mind that I am not considered
to be an expert in the reading of x-ray films relative to
asbestosis, but I do have a pretty reasonable working knowledge
of the art.

30 Over and above that, on very infrequent occasions
I would be called upon to review a file and to my recollection
this has not occurred specifically with an asbestosis case, where

5 A. (cont'd.) the situation was in the appeal structure and where they had already sent the file to Dr. Dowd for his senior opinion, and following that they still were not in a position to resolve the problem to their satisfaction. These are the people involved in the appeal themselves, be it the appeal board or the appeal adjudicator, and they then have the authority to refer such files to my attention.

10 The vast majority of such files that I receive, of course, are not related to asbestosis but are related to complex trauma.

15 Q. Would you be getting those files after the appeal board has considered the evidence in a particular case, or after the appeals adjudicator has considered the evidence, but before rendering a decision?

A. Yes, that is correct.

20 Q. Can I ask you this, in your capacity as executive director, and bearing in mind your last answer, have you or do you from time to time give any instructions to your medical consultants, particularly Dr. Stewart and Dr. Dyer, as to how they should approach the disposition of asbestos-related claims, or their responsibilities in respect of those claims?

25 A. In that context, and it's not unique to asbestos claims, I must assure myself from time to time that indeed the medical staff of the Board are dealing with all the claims in an impartial and in a uniform manner.

As you can appreciate, it would not be at all correct...and indeed it could be a real disservice to the injured workers...if one physician was rendering a decision which would be at wild variance or significant variance from another physician.

30 Similarly, I continue to have interest in how the medical memos are placed into the file to...and again, this is not

5 A. (cont'd.) restricted to asbestosis cases...to ensure that the content of the memo reflects the area of responsibility of my medical staff - namely that they are with the Board to hand down their professional scientific opinions relative to cause/effect relationships, this sort of thing, and they are not with the Board to adjudicate claims.

10 Q. How do you ensure that kind of uniformity amongst your medical people, and let's take the asbestos claims as an example. How would you ensure that there is some measure of uniformity in the disposition of those claims?

15 A. Well, one thing I do is from time to time I just take a sampling of files that are coming through Dr. Dyer and Dr. Stewart's offices, and just go through them and take a look at them...the same as I do files coming across the desks of section medical advisors that are dealing with general trauma cases, and surgical consultants and so forth...and the other way that I do is that, as I say, from time to time that indeed I do discuss how the physicians are handling the files - not only with the physicians, but also with Dr. Dowd, and Dr. Dowd acts on my
20 behalf and he, too, has the responsibility to ensure that there is uniformity in decision making with the medical staff.

25 Certainly, of course, this is of particular importance in the area of permanent disability or permanent impairment, and the positions that are responsible for doing that. It's extremely important that they hand down uniform decisions.

Q. Do you attempt to do the same thing - that is, to ensure some measure of uniformity - in respect of the asbestosis claims which we have heard inevitably, if they are going to be allowed, go the advisory committee on occupational chest disease?

30 A. I'm not quite sure I follow you with the statement that 'inevitably if they are going to be allowed go to the chest advisory committee'. I am not aware that that is

A. (cont'd.) one of the criteria for referral.

I would suggest to you that the cases that are referred to the chest advisory committee are those cases where, as a result of claims services investigation, that it has been established that there has been exposure to asbestos, and where it appears that there is a claim that must indeed be evaluated as to medical diagnosis, as to any degree of impairment that exists, and that's the two areas of responsibility that we have - namely, to establish a diagnosis and to determine what degree of impairment, if any, exists, and of course in conjunction with that, quite naturally, to ascertain the same as responsibility elsewhere in the medical branch, that the correct treatment is being administered by the most appropriate outside physician at the correct moment in time.

So that this is the method of referral to the chest advisory committee.

Q. My understanding had been...and please correct me if I'm wrong...but my understanding had been that in order for a claim for asbestosis to be allowed, to be compensated, that it would have to go to the advisory committee on occupational chest disease?

A. That is correct.

Q. And is that...my understanding, then, is correct.

Do you, yourself, have any liaison with the advisory committee on occupational chest disease?

A. Yes. I meet with them on occasion, or members of the committee, or visit with them over in their offices on Grosvenor Street, and I enter into discussions with Dr. Roerbeck, the chairman of the committee, from time to time, to ascertain what their activities are, any problem areas that they have, and over and above that Dr. Stewart and Dr. Dyer have responsibility to report to me through Dr. Dowd of any concerns that they might

A. (cont'd.) have relative to the committee, so that I can be made aware of those concerns.

5 Q. Can you help us, because we've, I think, at least as a result of the testimony we've heard to date, I'm a little confused as to who the actual members of the advisory committee presently are, as opposed to persons who may be consultants.

10 Can you help us as to the present composition of the advisory committee?

A. Well, the composition of the chest advisory committee are made up of those persons who the Board consider to be very knowledgeable in the field of respiratory diseases, and in particular diseases generated from exposure to silica dust and to asbestos dust.

15 It varies from time to time as people retire and new people are added to the committee, but currently we have a mixture of personnel that are on the payroll of the Ministry of Labour, physicians; physicians who have been on the payroll of the Ministry of Labour or Ministry of Health, such as Dr. Roerbeck, but who are retired, but who continue to function as members of the committee; persons who are in the academic world, such as Dr. Muir from McMaster University in Hamilton; persons who have been on the staff of the university or university hospitals, such as Dr. Cameron Gray.

20 So we have a mixture of people...and oh, yes, I forgot currently we have one member who is on the staff of the Ministry of Health, who serves as a member of the chest advisory committee. This is the composition of the chest advisory committee. They are all persons who have experience in dealing with what is essentially a rare disease. If you look at the number of cases of asbestosis and you look at the number of cases of other types of chest diseases, it is a very rare disease, so that

A. (cont'd.) only a very few people ever have sufficient exposure to gain expertise.

The ...

Q. Can I ask you this? Part of our confusion has been where...two of the members you named, Dr. Gray and Dr. Muir, are in fact members of the committee?

A. Yes, they are.

Q. Or consultants to the committee?

A. No, they are members of the committee.

Q. They are members of the committee?

A. Yes. They are in the same category as any of the other members of the committee - Dr. Roerbeck, Dr. Roos, Dr. Vingilis, Dr. Mehle and so on, I've forgotten...

Q. Vingilis and Dr. Budlowski?

A. Budlowski, yes.

They are all in the same category, that they are members of the committee and no distinction is made.

Q. Although we did hear some evidence from Dr. Gray which I relate to you, which was that he and Dr. Muir do not meet, do not meet with the advisory committee all of the time that the advisory committee meets, and at least Dr. Gray's evidence was that he and Dr. Muir are called in on the more difficult cases, and as I recall his evidence...

A. I can't verify that.

Q. You can't verify it?

A. I do know that at any given time that the chest advisory committee meets very regularly, every two weeks, and at any given time, because of vacation, illness and so forth, it's quite possible and quite likely that one or more members of the committee might be absent from a given meeting, including Dr. Gray and Dr. Muir.

5 DR. DUPRE: To your knowledge, Dr. McCracken, do all of the members of the advisory committee examine patients from time to time?

THE WITNESS: To my knowledge I believe they do, yes.

DR. DUPRE: Including Dr. Muir and Dr. Gray?

THE WITNESS: I believe so.

10 MR. LASKIN: Q. You mentioned before that the number of members on the advisory committee change from time to time?

THE WITNESS: A. Yes.

Q. Is what we have now fairly typical of the number on that committee or are we below size or above size?

15 A. No, I would say that it's fairly typical, looking into the past, as to the numbers. But there is no magical number relative to the chest advisory committee. If there were several physicians who would come along today, that we would consider to be valuable additions to the committee, and they were prepared to become members of the committee, I'm sure that very serious consideration would be given to putting those persons
20 on the committee.

Q. Is there any...that's one of the questions I was going to get to...is there any mechanism within your branch, or any ongoing deliberation at your branch, as to how members of the committee might be replaced from time to time, or new members
25 appointed?

I mean, how do you deal with the situation where some of your members get to retirement age?

30 A. Well, a good example of that currently is Dr. Vingilis, who retired from the Ministry of Labour this past year, and we were of the opinion that he was a valuable member of the committee and we did not want to see him leave the chest advisory committee unless it was his intention to move away from Toronto

5 A. (cont'd.) and be unable to continue, or some other reason, so therefore we discussed the matter with Dr. Vingilis, and we ascertained that he was quite prepared to continue to serve on the committee.

So....that is an example as to how we deal with a continuing member of the committee.

Q. Who is 'we'? When you say 'we' discussed it?

10 A. We is Dr. Stewart and Dr. Dowd, will evaluate the requirements and will then discuss the matter with me.

Q. How do you deal with the situation where a member of the committee may retire, period, from the committee?

15 A. Well, that, of course, is their decision. A good example of that is Dr. Roerbeck, who is currently the chairman, and each year Dr. Roerbeck telephones me or I telephone him, and I will ask him a question - are you prepared to serve as chairman for a further year, because I am quite prepared and would like you to continue for a further year, and we reconfirm the fact that he is agreeable to continue, and indeed then he will.

20 So that the time is going to come, this year or next year - who knows when Dr. Roerbeck will say, no, I want to retire, and when that happens, well, then it is our responsibility to take a look at the members of the chest advisory committee, to take a look at outside persons that we consider to be
25 adequately trained and knowledgeable in this specialized field, and replace Dr. Roerbeck as chairman and replace the vacancy that is created.

30 In other words, my approach is that I would not like to see the present size of the committee diminished through attrition. If Dr. Vingilis or Dr. Roerbeck were to retire, it would be my intent to replace them with new members coming on the committee - not necessarily to replace them in their positions,

A. (cont'd.) of course.

5 Q. Is there a potential candidates list floating around anywhere in your branch?

10 A. Not really. What we must do is we must take a look, and indeed we identify people who are involved in occupational health and people who are knowledgeable respirologists who have a particular interest in this field, and what we would do is we would then go to these people and see what their interest might be.

For instance, right now there is one of the Ministry of Labour staff who, in my opinion, has the adequate training now in reading of x-rays to be a potential addition to the committee.

15 Q. Who is that?

A. That's Dr...what's the radiologist's name, for the Ministry of Labour?

DR. DYER: Chan.

THE WITNESS: Dr. Chan.

20 I might say that in my opinion, it's extremely difficult to ever really have a list of potential candidates, because it's such a highly-specialized area of expertise that it's almost impossible to maintain such a list. The best you can do is to identify those persons that have a particular interest and that we are aware have demonstrated a particular knowledge in this field, and of course those are the people that we are exposed to - the respirologists primarily - who carry out evaluation and treatment of patients.

25 Q. Who has that responsibility for identifying persons who have sufficient interest and experience to become members? Who has responsibility within the Board for that?

30 A. Essentially the decision rests with myself, but before I arrive at a decision what I do and what I would do

5 A. (cont'd.) and will do is to consult with Dr. Stewart and Dr. Dyer and Dr. Dowd, and also consult with members of the current or the then-current chest advisory committee, because bear in mind they are the people who also know of the other professionals who have special interest and expertise in that field, so that would be a great source of consultation.

10 Q. You mentioned that you, yourself, meet with the advisory committee on occasion, from time to time, and you have discussions with the chairman.

A. Yes.

15 Q. Can I ask you, what is the purpose of your meeting with the committee and you having discussions with the chairman?

20 A. Well, the purpose of my discussions and the occasional meeting with the committee is, for instance, several years ago we met with the full committee and one of the main topics that I wanted to discuss with them was any problems that they might be encountering in the flow or processing of cases through the committee. These sorts of things are what I like to discuss with them from time to time.

25 Q. Do you ever give any instructions to the committee as to how they are to carry out their responsibilities?

30 A. Not directly to the committee. To the chairman of the committee, Dr. Roerbeck, on several occasions. I have in the course of general discussions indicated to him that the purpose of the committee, one of the purposes of the committee and one of the main purposes, is to determine the clinical impairment in the cases which they are seeing, and to ensure that indeed they address themselves to this and restrict themselves to this.

In other words, the committee does not have the

5 A. (cont'd.) responsibility to either adjudicate, nor do they have responsibility to take into account the handicap factors, the socioeconomic aspects.

Q. Excepting that, do you tell the chairman in any more particulars as to how the committee ought to be dealing with the question of impairment? Do you give them any guidelines as to how they should approach, what percentage ratings to attach?

10 A. No, I don't, because in my opinion physicians, especially those persons who have gone into specialized training, are fully equipped to carry out evaluation of clinical impairment. That's part of the training of a physician as far as I am concerned, and a physician is indeed equipped to ascertain what the clinical impairment will be.

15 Unfortunately, as you can appreciate, there are many physicians that have a mushy definition of impairment, and they tend to include in impairment factors that are not truly impairment, but are the socioeconomic aspects, and this is where much of the confusion arises, of course.

20 But, no. Physicians are equipped to evaluate clinical impairment, in my opinion.

25 Q. So, for example, if a new member of the advisory committee comes on board, with his whatever additional knowledge and experience he ought to have in assessing clinical impairment, I take it he would get it on the job, as it were? He is not going to get any special training from you or from members of your staff?

30 A. No, it's a process - he brings with him his own expertise and his own training - and by a process of exposure and osmosis, he will appreciate the role of the members of the committee, and of course the chairman of the committee is there to offer direction, suggestions and to clarify issues.

Q. Do you ever get into the job of reviewing any

5 Q. (cont'd.) of the files dealt with by the advisory committee in the same way that you review files dealt with by Dr. Stewart or Dr. Dyer?

A. Well, by the time that I see the files, they have already been seen by the chest advisory committee, so that part of the documentation on file will be a report of the committee.

Q. I see.

A. That would be the context.

10 Q. Have you ever had occasion, having looked at some files of the committee, to for example, have some concern that perhaps their assessment of impairment may show a trend that is too low, for example, in your judgement, cause you to go back to the committee and discuss that sort of issue with them, and perhaps suggest...say to them I am a little concerned that there
15 seems to be a tendency here in a number of cases to assess impairment, perhaps ten percent lower than I think might be appropriate - something like that? Has that ever happened?

A. Well, to my recollection there has only been one case since I have been in my present position, that was
20 brought to my attention by Dr. Stewart, to my recollection, where some concern had been expressed by Dr. Stewart that the percent impairment did not appear to be appropriate.

He had already dealt with the matter, but he brought it to my attention in the course of a discussion that we had relative to consistency of decision making, and this particular
25 case stuck in his memory and this is how it was brought to my attention.

But other than that, that's the only case that I can recollect, and indeed in my opinion that's the way it should be, because these people on the committee are the experts
30 in evaluating impairment as well as making a correct clinical diagnosis, and if we were seeing any numbers of cases at all

5 A. (cnt'd.) where there was a disparity of opinion or where there was evidence of inconsistency in diagnosis or level of impairment evaluations, then I would be really concerned because that would indicate to me that the people on the committee did not have the capabilities to function on that committee. But that has not been the case.

10 Q. I suppose my question is, how would you detect that if it was occurring? That's what I'm not clear on. How, if there was that inconsistency or if their ratings were, you know, not in accordance with sound expert judgement, how would you detect that?

15 A. Well, the obvious method of detection is that Dr. Stewart and Dr. Dyer act as a double check on the chest advisory committee.

20 In other words, all decisions of the chest advisory committee come across their desk and they are in a position where, based upon their experience and based upon, say, past performance of the committee, should there be any significant departure they would immediately become aware of this and would in turn bring it to my attention through Dr. Dowd.

25 Q. A while back in your evidence you stressed the fact that what you wanted your medical staff to deal with was cause and effect relationships, and one of those cause and effect relationships has been of some concern to this Commission, and can I ask you for your guidance on it? It is the situation where a particular worker may have a permanent partial rating for asbestosis - something less than a hundred percent - and then dies, and the cause of death is something other than asbestosis. A claim is made by a survivor for pension benefits and presumably the Board is then called upon to determine, 30 under section thirty-six of the Act, whether indeed that survivor is entitled to pension benefits.

5 Q. (cont'd.) The question then becomes, under what circumstances can it be said that asbestosis played any part in the cause of death, or indeed a sufficient part in the cause of death to warrant compensation.

Can you help us on that? Do you give any instructions or guidance to your medical staff on the question such as that?

10 A. Well, the only guidance that they receive... and when I say 'they', I mean Dr. Stewart and Dr. Dyer...is similar to the guidance received by all other members of the medical staff, and that is that it must be established, be it asbestosis, be it lung cancer, be it a fractured femur, it must be established that if the person who has a permanent partial
15 disability dies, that we must satisfy ourselves that the cause of death is related to his compensable injury, from a medical standpoint, and supply that information to the claims adjudication staff so that they can then apply the Act.

20 Or, conversely, that we cannot establish a relationship between the disease that gave rise to the individual's death and the compensable disease or injury.

25 Q. How close does the relationship have to be, and what we've seen is...and it's in Professor Barth's report... what we have seen is a number of cases in which survivor benefits have been denied, where the cause of death in some instances, for example, was bronchial pneumonia, in others it was myocardial infarction? What I'm striving for and some assistance from you is, how close does that relationship have to be? .

A. Well, by and large it must satisfy the cause/ effect relationship of being probable from a medical standpoint.

30 In other words, by and large a person that has asbestosis does not predispose that individual, that I'm aware of from any studies that I've seen, to coronary artery disease, and

5 A. (cont'd.) therefore if that individual were to die from a coronary artery occlusion, I would feel that my medical staff would be hard pressed to establish a cause-effect relationship between a person dying from a coronary occlusion and asbestosis.

10 Now, on the other hand, if the individual were to die from cardiac failure and it was demonstrated that he had clinical evidence that he was suffering from cor pulmonale as a result of fibrosis from his asbestosis, then so far as I am concerned that would be a very reasonable cause-effect relationship, so we would conclude that that person's heart failure, which led to his death, was related to his compensable condition.

MR. LASKIN: Dr. Mustard?

15 DR. MUSTARD: I would just like to pick up, if I could, on the myocardial ischemia problem, and we asked the same question of Dr. Gray.

20 If I recall the way it was posed, is that recognizing that chronic chest disease and development of hardening of the arteries may be independent processes, that when you do develop extensive narrowing of your coronary arteries, the oxygen-carrying capacity of the blood that goes through those arteries can become important. I think all of us medically have experienced situations where people have anemia or other conditions in which, if we exercise individuals, an electrocardiogram on the myocardium can develop, show ischemic changes in the myocardium, which do not occur when you restore their full
25 hemoglobin levels for carrying oxygen.

30 So the question that was posed to Dr. Gray is, it's possible that there might be a small cohort of people within the chronic chest disease field who do have some extensive narrowing of their coronary arteries - maybe less frequent than in other populations - and would they not potentially be vulnerable, if they had chronic chest disease, to reduced

5 DR. MUSTARD: (cont'd.) oxygen carrying capacity going through diseased coronary arteries, and could that not be a factor in causing transient episodes of ischemia - not occlusion - and occasionally, we know, that those transient episodes of ischemia can cause abnormal rhythms, ventricular fibrillation and death. We posed the problem to him as to whether that possibility could exist, and I think his answer was 'yes, with extreme chest disease it might occur'.

10 I wonder if you would care to comment on that possibility?

15 THE WITNESS: Well, appreciating that I am not a respirologist, but harking back to some of my earlier research that I did, we concluded that indeed there had to be a very significant shunt of nonoxygenated blood through a significant part of the lung - namely, at least one half of the lung - before there was an identifiable lowering of oxyhemoglobin levels.

20 So in order for that to be a factor in the hypothetical case that you cite, it would be my opinion, and I would certainly agree with Dr. Gray, that the individual would have to have extremely severe pulmonary fibrosis with a significant shunt of nonoxygenated blood.

25 DR. MUSTARD: Now, given that point, and obviously as you come down the scale of the degree of chest disease, you reach a point where you are comfortable that there is not going to be likely an effect, but then you get into a grey area and then you get into a black area.

30 When a person who has had as a diagnosis, asbestosis, dies with a report of myocardial ischemia, myocardial infarction, is there a careful check made as to whether that chest disease at the time of death has deteriorated to a point where it could have been a contribution to the infarction? Can you get that information, or is that something that is hard to get in all causes of death?

THE WITNESS: Well, as you can appreciate, that varies from case to case, or would vary from case to case, and it's predicated upon the individual clinician that's involved.

As you are well aware, there are some clinicians that write very detailed notes in the hospital records, and it's just a pleasure to go through the hospital record because you can obtain vast amounts of information on such subjects as that, whereas there are other clinicians - just as well trained - and unfortunately their notes leave much to be desired, so that in hindsight, when you start evaluating these, it can be pretty difficult.

DR. MUSTARD: So that in effect you could have a bit of a problem in determining what the state of the chest disease was at the time of death, in some of the people who have been given a disability for asbestosis?

THE WITNESS: Well, as it relates to the hospital records, but bearing in mind that these people are on the surveillance program if they are still employed by the Ministry of Labour, and have pulmonary function studies carried out if they are showing signs of deterioration, and if they have a claim with the Board, they are also in the group then that are called back for review of their condition. Consequently, we usually have a good base of clinical data that we can refer to which would indicate the status of their pulmonary function within a number of months, possibly up to twelve months, prior to any such episode occurring.

MR. LASKIN: Q. Can I just go...one question on the advisory committee, which I forgot to ask you before, which is - to whom is it advisory?

THE WITNESS: A. It is advisory to the Board.

Q. When you use the term 'board', what do you mean by that?

5 A. Well, I suppose that theoretically, similar to any other areas of operation relative to the Board, that any of these special groups theoretically should be reporting to the corporate board of the Board, or to the representative of the corporate board. In this instance the delegation of authority has been placed with me.

Q. Essentially through Dr. Stewart?

A. That is correct.

10 Q. Can I ask you just a few questions about the guidelines for asbestos-related diseases, and I take it you are familiar with those guidelines?

A. Yes, I am.

15 Q. I note that the dates when those guidelines came into being seem to coincide with your joining the WCB? Is that coincidence or did you have some part to play in the promulgation of those guidelines?

20 A. Well, it's partially coincidental, I would say. But indeed, one of the things that I addressed myself to when I assumed my position was, again, my concerns about assistance in decision making to the claims adjudication staff, and also consistency in evaluation, medical evaluation.

25 It was my opinion that wherever possible that guidelines of various types should indeed be developed, because this would be of real assistance in the handing down of uniform decisions. Not that the guidelines would act as a block to the allowance of claims, but as the title indicates, that they are indeed guidelines, to be of assistance.

30 So that, yes, I was extremely interested in the development of appropriate guidelines, and since 1975, yes, we have developed a rather significant number of guidelines...I believe about a dozen of them.

Q. Which, I take it, go beyond the asbestos-related

Q. (cont'd.) diseases and go into other areas?

5 A. Oh, yes, yes. There are guidelines into lung cancer in coke oven workers, and revisions of guidelines in lung cancer and arsenic exposure, and guidelines in vibration-induced white finger disease in hard rock miners and people working with power saws and so forth, these sorts of things.

10 DR. DUPRE: Do I take it that nearly all of the guidelines that have been formulated relate to industrial disease, with the possible exception of power saws, which you just mentioned?

THE WITNESS: No, that indeed will also be an industrial disease.

DR. DUPRE: Oh, that's the vibration aspect?

THE WITNESS Yes.

15 DR. DUPRE: So they have all been in the area of industrial disease?

THE WITNESS: That's right, because by and large such guidelines are...have a limited application in the field of trauma. For instance, you really don't need a guideline to ascertain that a person can fracture his leg if he falls off a ladder. So under those circumstances it's quite crisp and clear.

20 MR. LASKIN: Q. Is it you who, in practical terms, have final responsibility for the promulgation of guidelines in the industrial disease field?

THE WITNESS: A. Only so far as to satisfy myself that the medical aspects have been addressed. The way that the guidelines are developed, first of all, the area of need is identified and...

25 Q. Who does that?

30 A. It's a joint effort of myself, Dr. Dyer, Dr. Stewart, Dr. Dowd, some of the people, the executive director of claims services division from time to time, Dr...at least Bill Kerr, when he was the executive director, has on occasion raised the

A. (cont'd.) question, 'should we have a guideline to address ourselves to this particular problem'.

5 Q. What determines need? The volume of caseload coming in on a particular claim?

A. No, not necessarily. The need is identified by virtue of the fact that we recognize that these are difficult cases or complex cases, or cases where there appears to be some difference of opinion existing, and obviously that something should be done to establish some reasonable base to work from.

10 So once this is identified, then my involvement is to instruct the persons involved in the area - for instance, for vibration-induced white finger disease, I instructed our industrial disease consultant, Dr. Burton, to research the world literature and to develop a position paper as to exactly the magnitude of the problem, etc., etc.. Similarly with asbestos, what happened there was, following discussion on the matter, Dr. Ritchie, who I believe has appeared before the Commission, was requested to review the world literature, in view of his ongoing interest in the field of silicosis and asbestosis. He was very knowledgeable with the world literature and we asked him to carry out a review of the world literature, and to carry out a preliminary analysis of it.

15 So these are the steps that are taken leading up to the development of a position paper, and a position paper will almost invariably include a first draft as to what the guidelines should look like.

20 Now, there are certain standard aspects of guidelines which you may be familiar with. One is that part of the guideline is that we must define that indeed it does apply to a specific section of the Act.

25 Another common denominator in guidelines is that we must have an escape clause so that no one in the adjudication

A. (cont'd.) is locked-in to the guideline, that they have the capacity of looking at the individual case beyond the guidelines.

Then the heart of the guidelines, of course, are such things as the intensity of the exposure, or the duration of the exposure, the latency between first exposure and the onset or identification or diagnosis of the disease, the period where it applies, where the risk will diminish if risk ceases - these sorts of factors, and they will be part of the preliminary document that is developed.

When that document is developed, then the policy which I have developed is for the medical staff involved in the development of the guidelines, or draft guidelines, are to meet with myself and with Dr. Dowd as the director of the medical branch, and where it's applicable, to meet with any outside consultants that we might have gone to to go over the medical aspects of the guidelines to ensure that we do not require to do any further search, any further evaluation.

Indeed, in certain guidelines we did have to carry out special studies, and in the case of laryngeal carcinoma we prevailed upon Dr. Anthony Miller to carry out further studies on our behalf, which were used in the development of the guidelines.

Once we have satisfied ourselves that we have researched the problem sufficiently that we have established a cause-effect relationship, that we have established draft guidelines which appear to meet the needs and requirements, then the next step is for me to advise the executive director of the claims services division, because bearing in mind that these guidelines are used primarily in the claims adjudication process, the medical aspects, of course, must be addressed, but also the claims adjudication staff must look at the guidelines and use the guidelines for their direction in the adjudication process.

5 A. (cont'd.) So at that time we will set up a meeting jointly between the executive director of claims services division and myself, and our senior staffs who have been involved or who will be involved, and we will then have a meeting...or very often it's more than one meeting. In many of the guidelines we have gone through up to six or seven revisions of the basic guidelines during the course of our meetings, before we are satisfied that we have addressed the problem to our satisfaction.

10 When we have concluded that and when we are all in agreement that the guidelines meet our requirements, then the guidelines are presented to the corporate board by the executive director of the medical services division and by the executive director of the claims services division, as a joint document to be used by the two divisions.

15 Q. Has there ever been an occasion when the Board has changed a recommendation coming from you and your counterpart in claims?

20 A. Yes.

Q. Any involving asbestos?

A. No.

MR. LASKIN: Dr. Mustard?

25 DR. MUSTARD: Could I ask you a question, and I guess you don't have a copy of Barth's report in front of you, but on page five, thirteen he makes a statement about how the guidelines for asbestos-related diseases were developed.

30 He implies that there was a subcommittee of a management committee struck, and listening to your description, I wonder if you could tell me whether what Barth says there is really a reflection of what you are saying - that indeed there is a management committee, and if there is a management committee I would appreciate knowing who is on it and who sets it up, etc.

5 DR. MUSTARD: (cont'd.) If it doesn't exist, how would you interpret what you have said against what Barth has said, stated?

THE WITNESS: Well, there is a management committee, and the management committee is made up of the executive directors of all of the operating divisions of the Board, plus the actuary, plus the auditor, plus the registrar of appeals.

10 Pardon me...plus the...not the registrar of appeals, plus the legal counsel.

Dr. Barth, I noticed that when I read his report, and that is an error, in my opinion, in his report, because indeed this is not a part of the management committee except by virtue of the fact that myself and the executive director of the claims services division are also members of the management committee.

15 But the management committee per se have no input into the development of the guidelines, but rather the guidelines would refer directly to the corporate board.

DR. MUSTARD: So that you and the head of the claims division would establish your subgroup to develop guidelines, then the two of you would present that to the board?

20 THE WITNESS: That's correct.

DR. DUPRE: Could I just...perhaps, Dr. Mustard, if you could show the copy of Barth to Dr. McCracken again...I just want to make sure I understand the corrections that should be made here.

25 First of all, let's just go to five, twelve - the paragraph at the bottom lefthand corner. There the statement is made that:

"A subcommittee of the Board's management committee was formed to establish guidelines".

30 Now, the point of correction that you would make is that basically you and the executive director of the claims division simply decided

DR. DUPRE: (cont'd.) to form a group to establish guidelines?

THE WITNESS: That is correct.

DR. DUPRE: Okay. And the management committee as a whole was not involved?

THE WITNESS: No.

DR. DUPRE: But you and your counterpart from claims did, nonetheless, set up a group?

THE WITNESS: Yes.

DR. DUPRE: And that group consisted of what individuals in terms of their responsibility?

THE WITNESS: Well, on the claims side, the director of the claims adjudication branch and one or more of his representatives, senior management people, and the director of the claims review branch who would have to review any initial adverse decisions and therefore must be privy to development of such documents, and his people that he might wish to involve... usually one or two people.

In the medical branch it would be Dr. Stewart and Dr. Dyer as it relates to asbestos, Dr. Dowd, the director of the medical branch.

DR. DUPRE: Okay. Now, I've got that basically straight. That was really a committee or a working group that was set up really by the two executive directors?

THE WITNESS: That's correct. As a matter of fact, this is the modus operandi which is used at the Board, where we have an issue that must be resolved and it involves more than one division, then the way we approach it is that we will identify those persons to serve on a special ad hoc committee, to meet and to make recommendations.

DR. DUPRE: Now, going over to five, thirteen, then, in the paragraph that begins in the middle of the page, the second

5 DR. DUPRE: (cont'd.) correction to Barth would be that the guidelines were recommended by this committee which you have just discussed?

THE WITNESS: The committee developed jointly between the claims services division and the medical services division.

DR. DUPRE: It was that committee that simply reported back to the two executive directors?

THE WITNESS: That is correct.

10 DR. DUPRE: Not to the WCB management committee?

THE WITNESS: No.

DR. DUPRE: Right.

And then at this point, it is correct, I gather, that they were made official by approval of the corporate board?

15 THE WITNESS: That is correct.

DR. DUPRE: But it was you and your counterpart executive director from claims who placed those guidelines or asked that those guidelines be placed on the agenda of the corporate board?

THE WITNESS: That is correct.

20 DR. MUSTARD: Can I ask a question? Do you do that through the vice-chairman of administration, Dr. McDonald?

THE WITNESS: Usually we do it via the secretary of the board, but having said that, the vice-chairman of administration is advised that we intend to place such an item on the agenda.

25 DR. DUPRE: Can I just ask one other question about five, thirteen, while we are dwelling on that page? Maybe if you could show that, Dr. Mustard, to Dr. McCracken....this is going back to your dialogue with Mr. Laskin about the extent to which the activity of the guidelines and your own moves back in to the WCB were interconnected.

30 Professor Barth states, on five, thirteen:

5 DR. DUPRE: (cont'd.) "The specific recommendations that became the guideline emerged from a study undertaken by a pathologist at the University of Toronto, Dr. A.C. Ritchie, that has been commissioned in 1974."

Now, do I take it from that that the idea of having guidelines was very much in place before you went to the Board as executive director?

10 THE WITNESS: No, I don't believe that that was a fact. They were not identified as wishing to develop guidelines per se, but rather what they wanted to do was to take a very hard look at such...especially the condition of bronchogenic carcinoma, because in other jurisdictions, and even today it remains so in some jurisdictions, the prime guideline for acceptance of
15 brocnhogenic carcinoma in persons exposed to asbestos fiber dust is that they must have a clinical diagnosis of asbestosis before such a diagnosis will be considered as cause-effect related, and the Ontario Board in 1974, and prior to 1974, going back, I believe to about 1972, 1973, were becoming more and more concerned that this was really not a good and reasonable scientific approach
20 to the problem.

Professor Ritchie was asked to carry out a review of the world literature, and also contribute his opinion in view of his ongoing interest in this field.

25 He did not develop the guidelines, of course. What he did was, as instructed, he reviewed the literature and he broke down the world literature as to those reports indicating a cause-effect relationship, those reports failing to identify a cause-effect relationship, and those reports that were primarily anecdotal and which he considered were inappropriate to be used.

30 In conjunction with that, he made his own individual comments on each of the documents that he reviewed, and also made general comments such as it would be his feeling that there had been

THE WITNESS: (cont'd.) a cause-effect relationship established, from his review of the literature, etc. But he did not develop the guidelines and the specific recommendations that became the guidelines emerged from a study undertaken by a pathologist at the University of Toronto.

That was only part of it. In other words, Professor Ritchie indeed supplied a very valuable degree of input to us, but that was only part of the input and the remainder of the input was the cases that we already had been dealing with, our experience which we had gained - namely Dr. Stewart in this particular field up to that point in time - and also the claims input as it relates to how those claims were being handled at that time, and the Act was being interpreted...and we weren't satisfied that we were interpreting the Act as we should, from a medical standpoint at least. We felt we had to have clearer and more concise medical input which would be of assistance to the claims adjudication staff, so all these factors were put together.

DR. DUPRE: Let me see if I understand something here. You moved in as executive director of the medical services division in 1975. Now, as I understand it, Dr. Ritchie by that time was already at work because he had already been asked...

THE WITNESS: That is correct.

DR. DUPRE: ...to establish the connection between asbestos and cancer?

THE WITNESS: That is correct.

MR. LASKIN: Q. By whom, by the way?

THE WITNESS: A. The request...my predecessor, Dr. Richardson, had been consulted by Dr. Stewart and Dr. Dowd, and he had agreed that Dr. Ritchie should be approached and should be commissioned to review the literature.

DR. DUPRE: Now, can I take it though that it was

5 DR. DUPRE: (cont'd.) you as executive director who, jointly with the executive director of the claims division, appointed that working group or committee that you were chatting about a moment ago?

THE WITNESS: Yes, that is correct.

DR. DUPRE: To work out some guidelines.

10 THE WITNESS: Yes. What occurred initially, as I mentioned, was that Dr. Richardson, my predecessor, had agreed that indeed we had to take a look at this, and Dr. Ritchie was busily engaged in developing part of the data we required.

15 Dr. Stewart took that data, along with data which he had developed, and observations of cases which had been previously dealt with by the Board, and developed a position paper indicating his opinion, based upon this data, as to how we might handle claims in the future - particularly, and we are now addressing ourselves specifically, really, to the mesothelioma and bronchogenic carcinomas because we did not develop at this time any guidelines for asbestosis. That stands on the medical aspects of the disease and also on the claims aspect.

20 At that time, then, I had directed that Dr. Dowd and Dr. Stewart and I'm not sure that Dr. Dyer was directly involved in that at that time or not, that they indeed continue to refine the document which they had developed.

25 We had a series of meetings, they met with me and when I was satisfied that we had a document...and this was by evolution at this stage of the game that we developed a first set of guidelines...and then I discussed the matter with Mr. Kerr, who was then executive director of the claims services division, and Mr. Kerr and his senior staff, who I have mentioned, identified their positions, had a joint meeting with us...as a matter of fact, a series of meetings...and we agreed that indeed these
30 guidelines appeared to address the requirements.

5 DR. DUPRE: One thing that interests me is, when you and your counterpart executive director of claims appointed the committee...incidentally, should it be called a committee or a working group?

THE WITNESS: I think that probably it should be called an ad hoc committee or a working group.

10 DR. DUPRE: So when you and your counterpart established this ad hoc committee, did you at the time you established that committee direct it to produce a guideline, or did you ask them instead to look at the situation and did the idea of maybe going to a guideline emerge as part of their own deliberations?

15 THE WITNESS: The latter would be the case, namely that they were requested to look at the problem and to make recommendations, and as an evolutionary process I rather rapidly, as I recollect, came to the conclusion that we were going to have to develop certain criteria which would be of assistance in helping us to deal with these cases, and they became known as the guidelines.

20 DR. DUPRE: One other question in this regard, if I might, Dr. McCracken. You mentioned a few moments ago in your dialogue with Mr. Laskin that over time a number of guidelines have been developed in the area of different industrial diseases.

25 Were there any guidelines with respect to any industrial disease already in place at the time this ad hoc committee was appointed, or was this kind of your pilot project on the way to developing your first guideline?

30 THE WITNESS: Well, yes, there were several documents. They were not identified as guidelines. They were identified as Board directives, because the corporate board had approved of them. The one was in the handling of lung cancers

5 THE WITNESS: (cont'd.) related to exposure to arsenic in the old DeLaurel mining operations, and the other one were the Board directive as it related to the handling of lung and sinus cancers in the sinter workers at Port Colburne and Coppercliff. But they were not guidelines per se.

10 For instance, the Coppercliff/Port Colburne Board directive indicated that favorable consideration would be given to cases where the individual had been exposed to sinter operations at Coppercliff for a certain number of months, and at Port Colburne for a certain number of months.

DR. DUPRE: They were directives that favorable consideration might be given?

THE WITNESS: That's correct.

15 DR. DUPRE: Now, does that mean that the early guidelines which were not, as I take it, really guidelines, they were later developed - that these early guidelines were Board directives that were basically eligibility criteria?

20 That is to say, if a worker has been in this particular mining situation for a certain amount of time, then that worker may be considered?

THE WITNESS: That is correct.

DR. DUPRE: Okay.

25 Now, how does that...how do these early guidelines, calling them that just as a useful shorthand term...how does the concept of these early guidelines differ from the concept of full-fledged guidelines as they start to emerge from 1975 on?

THE WITNESS: Well, I would think, for instance, one of the differences is that the early directives did not have any background documentation supplied with them. That was one difference.

30 The other difference is that they were merely directives and they addressed themselves in a very limited degree...

5 THE WITNESS: (cont'd.) for instance, the guidelines for lung cancer and sinur cancer in sintering operations were limited to number of months exposure. They did not make any reference or try to address themselves to other factors such as latency periods, etc., etc.

10 Now, these guidelines have been reviewed and revised, and we have attempted to address ourselves to the factors that we feel must be addressed in any of the guidelines - namely the inception period, the cessation intervals, the exposure intervals, the levels of intensity.

15 In some guidelines and some types of exposure, we have to leave gaps in the guidelines. It is impossible to define, for instance, exposure intensities, except in broad general terms, whereas in other situations, one can define the exposure intensity. So that I believe in fact it's apparent that what we have been able to achieve is better definition of the guidelines or better definition of the old directives.

MR. LASKIN: Dr. Mustard?

20 DR. MUSTARD: Perhaps you might like to help me a little bit with a point that Professor Barth talks about in terms of the guidelines, and I guess I should find the exact pages.

25 If you turn to page five, twenty-two, five, twenty-three, he concludes that in considering Ritchie's and Miller's reports, that the Board's guidelines for, say, lung cancer...I think that twenty-two and twenty-three may not refer specifically to lung cancer, but it's also true for the lung cancer section...that the Board's guidelines for continuous and repetitive exposure were stricter than what Miller and Ritchie felt they should be. That is, that they felt exposure was a more acceptable term.

30 What I would be interested to know is, in the process of developing the guidelines, who makes the decision to make it

DR. MUSTARD: (cont'd.) stricter? Is that your committee? Is that at the level of you and the claims officer? And the reasoning for that?

And in answering that, I would like to read you what I also gave to Dr. Gray when we were talking to him. It's an editorial by Margaret Becklake, in the New England Journal of Medicine, in June of this year, in which he states:

"Thus; in considering individual patients with a disease known to be related to asbestos exposure, the wise clinician should avoid regarding any particular exposure as too short, too remote, too low a level to have accounted for the disease".

I would appreciate knowing a little about the reasoning of putting that stringency into the cancer guideline when it doesn't appear to be the same in the asbestosis guideline...and at what level, particularly, that comes in in your process.

THE WITNESS: Well, first of all, having noticed this in Barth's report, I am of the opinion looking at Dr. Ritchie's documents, and Dr. Miller's, that indeed they did not make such a suggestion, but rather by default they felt that they were not in a position to make any specific recommendations along these lines.

Certainly Dr. Ritchie felt quite definitely, it's my recollection, that he, having reviewed the literature, was not in the position to make a definitive recommendation.

In the development of the guidelines, we took the data which Dr. Ritchie had developed, and we took the data which we had, and bearing in mind that we were developing guidelines, we took a reasonable duration of time for latencies or for exposure, where we were able to, and we then scaled that down to less than what the average would appear to be, so that we were

5 THE WITNESS: (cont'd.) erring on the conservative side, so that more claims would fit the criteria than would ordinarily fit it had we used what appeared to be the mean duration of time for latency and for exposure.

That was a safety factor that we felt should be put into the guideline since indeed they were being or were to be used as guidelines.

10 So that I don't know whether I answered your question or not, but...

15 DR. MUSTARD: I guess it would help me if I knew at what point in the development of a guideline this input would go into the final consolidation. Would it be at your level, of yourself and the executive director of the claims section, and the board level, or at the level of your committee?

THE WITNESS: It would be...that input would go into the guidelines when I would be meeting with Dr. Dowd, the director of the medical branch, and with Dr. Stewart and Dr. Dyer.

20 DR. MUSTARD: Now, can I ask you, how do you handle the dilemma that is posed by some of the, substantial, I guess, amount of epidemiological data that shows that exposure to asbestos for periods of time - three or six years - is associated with increased incidence of lung cancer? When you come to a guideline such as this, you obviously recognize that that evidence exists, and is the guideline being determined to make it administratively simple to administer with your escape clause at the bottom, that all cases can be reviewed in terms of those that are outside the guideline, to try to see if you can make a judgement medically about them?

25 THE WITNESS: Yeah. The guidelines are, certainly, as the name implies, they are to be used as guidelines.

30 I have had occasion to take a look at actual cases, and Dr. Dyer has carried out some analyses for me, as it relates

5 THE WITNESS: (cont'd.) to how close the guidelines
are to latency and to exposure intervals, and the mean and the
mode, indeed, do agree very well, and if you apply a standard
deviation, we find that the guidelines fit in excess of sixty
percent of the cases, and we think that this is most
acceptable....appreciating the epidemiological observations that
have been made that indeed there are individual cases where
10 exposures of less than the duration in the guidelines apparently
have indeed given rise to disease, and the experience of the Board
verifies the fact that our guidelines have worked well and the
clause in the guidelines allowing us to look at each case
individually has worked well, because there are approximately
twenty, I believe, up to twenty-five percent of the cases that
15 fall outside of the guidelines, below the guidelines, that indeed
have been accepted. They have been accepted on the basis of the
fact that it's a medically-reasonable assumption to make that
the exposure was indeed a significant factor in the development
of the disease.

20 So that the guidelines do appear to be fitting
very well, but with this particular type of disease there is a
wide standard deviation. No question about it.

25 DR. MUSTARD: In that question there is a problem
in epidemiology about making decisions on samples derived from
people who present themselves to you, which in a sense is what
is happening with the Board, versus doing a study the total
population exposed.

30 Have you had an epidemiologist like Dr. Miller
come in and look at the implications of trying to make a decision
on the population sample that comes to the Board, as opposed to
the broader survey of the total population exposed, to suggest
the limitations or restrictions that might be involved in terms
of looking at a more restrictive data base?

5 THE WITNESS: Yes. We didn't have someone come in. We had Dr. Allen Chovil, who was with us up until last year, and Dr. Chovil was involved in a number of epidemiological studies, in conjunction with outside persons in certain instances, and indeed he carried out an overall review of the cancer experience with the Ontario Board, looking at it from an epidemiological aspect, and his paper was published in, I believe it was the Canadian Medical Association Journal or the Occupational Health - 10 certainly one of them was published in one place or the other - and in his investigations he was satisfied that indeed we were identifying the majority of cases, and that those cases that we were not identifying were cases where when and if they are brought to our attention - such as in the search program - that there had been either no identifiable exposure or very limited exposure. 15

20 We feel that the unions have been very active and very responsible in identifying any cases that might have had a disease caused through exposure, and I would like to believe that many physicians that are dealing with this condition today have become much more aware of the possible cause-effect relationship, and will report cases to us, and indeed this happens not infrequently. We receive letters from physicians on a fairly regular basis, identifying certain cases of industrial diseases they have concerns about, which never happened until the past five or six years.

25 DR. MUSTARD: All the evidence that Dr. Chovil...?

THE WITNESS: Chovil.

DR. MUSTARD: ...developed is in that paper?

THE WITNESS: Yes.

DR. MUSTARD: Okay. So if you could leave us...do we have that paper?

30 MR. LASKIN: No, but we'll get it.

MR. LASKIN: Q. Could I just pursue for a moment

Q. (cont'd.) a question Dr. Mustard asked, and I'm just wondering whether we are being entirely fair to Dr. Ritchie.

I am looking at one of Dr. Ritchie's three reports, which is indeed an appendix to the brief which was submitted by the WCB to this Commission, and I'm looking at appendix three which was his supplementary report dated April 15, 1976, and he reviews the data and his supplementary report, as I understood it, was to review some further data, and then at paragraph A fifty-four...and I'll read it to you, Dr. McCracken, and show it to you if you wish...which is on page eight of that report, he draws certain conclusions and makes certain suggestions, among them being:

"F. That those with exposure to asbestos who develop carcinoma of the lung should usually be compensated if there is a history of adequate exposure to asbestos, or clear histological evidence of such exposure;

(b) fifteen or more years have elapsed since the beginning of exposure to asbestos".

Now, if I take that suggestion and put with it what I read in Professor Barth's report, that Dr. Stewart indeed agreed with Dr. Ritchie, that recommendation or suggestion of Dr. Ritchie's seems to have been changed when the actual guideline came into effect, and indeed I suppose was more lenient in one sense - the guideline was - in terms of the latency period, arguably harsher in terms of exposure requirements.

I guess to come back to Dr. Mustard's question, where did that occur in the process, and why did it occur?

THE WITNESS: A. Well, first of all, yes, it is... the guideline is more lenient as it related to the latency.

As I mentioned before, the reason for that is that indeed we agreed with Dr. Ritchie that the literature would indicate to us that a fifteen year latency period was very reasonable, and

5 A. (cont'd.) as a matter of fact at that time, having spoken to Dr. Selikoff, he was of the opinion that the average latency was twenty years, possibly twenty-five years.

Q. You spoke to Dr. Selikoff?

A. Yes.

So that indeed in the development of the guidelines we felt that we should stipulate a duration of ten, rather than fifteen.

10 Q. Why? This was the margin that you talked about?

15 A. The margin of safety, the margin of safety, so far as we were concerned. In other words, if they are to be used as guidelines we did not want to get into the situation where we would have to put forth an argument from a medical standpoint that since the person had only fourteen years of exposure, therefore it was, from a medical standpoint, unacceptable, because that was not the case.

This is the way that we have designed all of our guidelines is, we will back off from what appears to be the acceptable or mean interval of time.

20 Q. But on the exposure you plugged in a ten year requirement?

25 A. That's right. And we felt that we should make every attempt that we could to also put a time factor into the exposure, and I believe that we added one word to the guidelines - which was that I believe there is a 'clear history', I think that that was it, a 'clear history' or a history...

Q. Clear and adequate?

30 A. Clear and adequate. And we felt that clear allowed us better definition. In other words, we felt that it was important that we were able to establish that the person did have a very definitive exposure to asbestos fiber dust, and we felt that a clear history would be better understood by the claims

A. (cont'd.) adjudication people who were going to be using the guidelines.

Q. So that was essentially your input, I take it?

A. That is correct.

Q. So if we come up...

A. You say 'your'. That was the input of the group.

Q. All right.

DR. DUPRE: Oh, of the ad hoc committee that you and your counterpart in claims...

THE WITNESS: That is correct. That would be the input of the group consisting of claims personnel and medical services division personnel.

MR. LASKIN: Q. Including Dr. Stewart?

THE WITNESS: A. Including Dr. Stewart.

Q. But he wouldn't have agreed with this?

A. Pardon?

Q. If Professor Barth is accurate, I take it Dr. Stewart wouldn't have necessarily have agreed with the ultimate resolution?

A. To my knowledge, all members on the ad hoc committee were in agreement with the guidelines. The way that we approached it was, in the design of the guidelines and in the wording of the guidelines, we were attempting to be particularly careful in the wording of the guidelines, for clarity and for intent of purpose, and to my knowledge, Dr. Stewart was in agreement with the final draft of the guidelines. I don't think there is any minority report there at all.

Q. All right. Can we just, while we are on this page eight, just come up to conclusion C, which says that:

"All with any exposure to asbestos, who develop mesothelioma, should be compensated".

Now, of course, when we actually look at the mesothelioma

Q. (cont'd.) guideline, what we see is a ten year exposure requirement and a fifteen year latency requirement.

Can you help me as to what happened to Dr. Ritchie's suggestion between the time he made it and the ultimate pronouncement of the guideline?

A. Well, nothing happened to his suggestion. Indeed, it was taken into consideration. But again, we felt that we had to try and be a bit more definitive than to develop a guideline which would be so vague as to not serve any purpose not so ever.

In other words, what we have been attempting to do is to develop a document which will be of assistance in the adjudication of these complex types of claims.

If you become so vague as to be totally nonspecific, then there is no purpose for the development of a guideline. Each case must be individually assessed on its own merit, which was the situation prior to the definitive guidelines, and which was giving rise to increasing concern because we are not convinced that we were applying the degree of uniformity in looking at these cases that we should be, and therefore in order to have a viable guideline we felt that we should take and must take the data from the acceptable portion of the world literature and arrive at an estimate as to what latency and duration should...duration of exposure should be.

Q. I'm wondering, with respect to mesothelioma, why it is terribly vague, simply to suggest that you look at a person and you make a diagnosis of mesothelioma, you then look at a work history. If you discover that he has had any exposure to asbestos you compensate.

A. There is no question about it that in applying the guidelines we have accepted cases of mesothelioma that have had very short intervals of exposure. No questions about that at all

5 Q. We've heard that, and I suppose ultimately my question is, and I have a couple of questions in this area, but ultimately my question is, why with a disease which...at least it's fairly cause specific to asbestos, if we can believe all of the epidemiological evidence that we've heard, bearing in mind there may be some causes of mesothelioma that aren't asbestos-related, but it has a very strong association with asbestos, why the stringency in the exposure and latency requirements?

10 A. Well, I wouldn't say that it was a stringency. Again, it reflects the experience of the documentation that has been developed in the world scientific literature - namely that it is not the rule that mesotheliomas occur with one-month exposure.

15 The rule is that mesotheliomas tend to occur with latencies as we have defined and with exposures that we have defined. These are the rules. They are the preponderance of the data which has been developed, and we feel that we are on pretty reasonable scientific grounds to take that approach, that if it is generally reported that a disease takes twenty years to develop, and if we say we do not want to make our guidelines too
20 stringent and give rise to problems in the adjudication of these claims unnecessarily, we will then reduce that latency from twenty years to fifteen years. We feel that we are on good scientific grounds for doing this because the preponderance of the literature indicates that this is when the majority, or the greatest number of cases indeed, do develop their disease - not at the extreme
25 ends of the scale.

Q. Okay. Could you go to page twenty-three of the brief you have in front of you...at the beginning, not in the appendices...and I just want to look at the lung cancer guideline with you for a moment.

Are you with me?

30 A. Yes.

Q. Okay.

Which has certain parts to it:

5 "(1) That lung cancer and asbestos workers be
accepted as an industrial disease"...and so on,
under section one, eighteen.

Paragraph two:

10 "That based on medical studies, lung cancer claims
be favorably considered when the following
circumstances apply"...and I take it the words
'favorably consider' hearken back to the early guidelines, to
use the Chairman's term?

A. The early directives, yes. Yes.

15 Q. "Two point one: There is a clear and adequate
history of at least ten years occupational exposure
to asbestos.

"Two point two: There is a minimum interval of ten
years between first exposure to asbestos and the
appearance of lung cancer, and

20 Two point three: The individual assessment".

Now, do I take it that for one class of claims, one should be
reading...there should be an 'and' between two point one and
two point two?

25 In other words, from the point of view of the
claims adjudicator, if he wants to make some determination of
compensation without an individual assessment, he will be looking
for some claim that satisfies two point one and two point two?

A. That's indicated in the preamble. It says
'when the following circumstances apply'. That's in the plural.

Q. Okay.

30 So that if two point one and two point two are
satisfied, can I fairly say that automatically a claimant is going

Q. (cont'd.) to receive compensation?

A. Yes, that's a fair statement.

5 Q. So that in terms of 'favorable consideration', it may be an understatement, at least in terms of two point one and two point two?

A. Yes.

10 Q. Then all of the other cases must be dealt with under two point three?

A. Yes, that is correct.

Q. Okay.

15 I asked Dr. Dyer this, or Dr. Mustard did, and I don't know whether you can help us on it: In terms of the lung cancer claims that don't come within two point one and two point two, what are we looking at in terms of applications for compensation acceptance or rejection?

A. You mean the ones that fall outside?

Q. The ones that fall outside the guidelines.

20 A. Off the top of my head, I would say with the lung cancer that we are looking at about twenty, twenty-five percent of the cases that do not meet the criteria as it relates to latency and duration of exposure, which have been accepted. With mesothelioma, the percentage would be about the same, which includes the vast majority...in fact, all of the mesotheliomas. There is not a single mesothelioma case that I am aware of that
25 has not been accepted by the Board where it has been demonstrated that there has been exposure.

Q. And in terms of the lung cancers, you are suggesting twenty-five percent of the cases that do not meet two point one and two point two are being compensated?

30 A. About twenty to twenty-five percent, I would estimate. Yes.

Q. Are you able to tell me of those, in how many

Q. (cont'd.) there was coexisting asbestosis?

5 A. I would say that to my knowledge there was not a single case of asbestosis in that group, because they were the group that had minimal exposure and therefore one would automatically expect that indeed they would not be showing any plaques, that they would not be showing any radiological evidence of asbestosis, and I believe that that is true. I don't think that there is a single case in that group where there is a
10 concurrent diagnosis of asbestosis, because if there had been then almost automatically that would indicate to me that there had been a significant exposure to asbestos fiber dust, and a significant duration of exposure, and the case would have met the criteria in two, one or two, two.

15 Q. And would warrant compensation?

A. And would warrant compensation.

Q. Are those statistics readily available?

The ones you have just been giving us your best recollecton on?

20 A. I believe that Dr. Dyer is developing some information for you on that...

Q. Okay.

A. ...the number of cases that fall outside of the guidelines.

Q. Okay. Perhaps we can leave it until then.

25 A. As I say, applying standard deviation to the guidelines, the guidelines fit in about sixty percent of all cases for exposure, I believe it is, and around about eighty percent for latency.

Q. Are you familiar with...I take it you are.. schedule three to the Statute?

A. Yes.

30 Q. Has schedule three been added to during the time that you have been executive director?

A. Not to my knowledge, no.

5 Q. You have given us your involvement in the establishment of guidelines, and indeed I take it from your evidence that you were a motivating for, in many respects, behind the promulgation of guidelines, and what I would like to ask you is, is there any relationship between that development and the fact that schedule three has not been utilized during your tenure?

10 In other words, have you elected by way of approach to deal with these matters by way of guidelines rather than considering the possibility of adding certain of the diseases to schedule three of the Act?

15 A. Well, certainly this was more of a concern to the executive director of claims service division, Mr. Kerr, than to myself, as you can appreciate, because he in his area of responsibility was more concerned as to whether or not schedule three should have additions made. But indeed the matter was discussed with me.

20 The vast majority, in fact all of the items listed in schedule three, tend to be those types of diseases where there is really very little, if any, argument about the cause-effect relationship, because they tend to be extremely specific.

25 The types of conditions we are talking about - bronchogenic carcinoma, the commonest malignancy in the male population today and multicausal in origin, - does not tend to be that specific, and therefore we felt that it would be extremely difficult to fit such a condition into a schedule three.

30 Q. But what about asbestosis and what about mesothelioma? Because it seems to me, on the surface, looking at it as a layman, that they might be natural candidates to be included in a schedule such as schedule three, and indeed you certainly find silicosis already, as you know, in schedule three.

A. Right. Well, I'm not aware of any reason for

5 A. (cont'd.) or against, arguments for or against the inclusion of asbestosis in schedule three, so I really can't help you there. All I know is that it was not in schedule three when I assumed my responsibilities, and the question was not brought forward as to whether or not it should be included in schedule three.

10 I suppose on the of the reasons that it wasn't is because asbestosis was being dealt with very well, in our opinion, namely that once the medical diagnosis was established and once it was also established that a person had exposure to asbestos fiber dust, that the adjudication of the claim was very straight forward.

15 The only problems that have been encountered in the adjudication of claims of asbestosis is the situation where the medical dianosis remains obscure.

20 As a matter of fact, that has created some very real concerns of ours, and that's why Dr. Stewart, with my concurrence and with my support, indeed did develop our own medical guidelines to identify asbestos fiber dust effect cases, and to my knowledge no other jurisdiction has developed such a guideline up to the present time. It's a very difficult area.

25 But we were indeed concerned that we did not want to overlook those cases which might, which might evolve into a case of asbestosis and the diagnosis be made. We wanted to be sure that they were tracked, and one way of tracking them was to identify them with a diagnosis of asbestos fiber dust effects - which did not mean that they had asbestosis, but it meant that everybody then had a raised suspicion index so that they would watch those cases more carefully.

30 Q. I'm going to ask you about that, if I can, but

5 Q. (cont'd.) just to complete this questioning, then your counterpart in claims, what concerns or views did he express concerning the advisability of utilizing schedule three on the one hand, or the advisability of dealing with industrial disease by way of guidelines on the other?

10 A. Well, as I mentioned, it was generally felt in multi-causal conditions that guidelines would serve the purpose better than attempting to force them into the schedule three groups. That was the one reason.

15 The other reason, presumably, was the possible policy decision on the part of the corporate board, not to put asbestos, for instance, into the schedule three listing. But I can't verify that, or at least I am not privy to that information, but it could have been a conscious decision by the corporate board that it should not be placed under schedule three.

20 Q. When you give us that evidence are you speculating, or do you have some ...

25 A. No, I am merely speculating that some time in the past the question might have been raised, and the corporate board, for whatever the reason might have been, decided that, no, it should not be put in schedule three, that it was being handled quite properly the way that it was being dealt with at that time. That is strictly speculation.

30 DR. MUSTARD: I was going to ask a direct question on that. I notice that vinyl chloride is not in schedule three, and it's a fairly specific problem that it carries, and then it was identified in the seventies, as well, it also causes cancer, and I notice that you really have no cancer cause-effect relationships identified in schedule three. I was wondering if, therefore, one can say it as a broader policy that the carcinogen area is one that you either have not had time to

5 DR. MUSTARD: (cont'd.) address in terms of the appropriateness of schedule three, or whether it's general policy just to keep the carcinogens out of schedule three because of the complexity of the problem - even though vinyl chloride is specific.

10 THE WITNESS: Vinyl chloride is not in schedule three, that's true enough. Again, I can only presume that the board elected not to put it in schedule three because once again, any vinyl chloride cases that we have had...and we've had about a dozen of them...have been readily dealt with because of the clear cut cause-effect relationship to exposure to the vinyl chloride.

15 Up to the present time, this Board has not had a case of angiosarcoma of the liver from vinyl chloride exposure. I believe that those cases are limited, in Canada, to the Quebec exposure - around about thirteen cases, I believe.

I'm just trying to recollect schedule three, and I'm trying to recollect what it says about radiation.

20 MR. LASKIN: Q. There is one cancer that I have noticed in schedule three...

THE WITNESS: A. ...because I didn't think it was excluding all malignancies, because it was my recollection that, for instance, it's under schedule three, I believe, as it relates to radiation...

25 DR. DUPRE: Any disease due to exposure to radiation?

THE WITNESS: Yes, that we deal with such things as our few cases of leukemia from radiation exposure, skin cancer from radiation, from fluoroscopic exposure and from...I believe we have had one skin cancer that was related to exposure to the use radium on luminous dials during the war, and so on.

30 DR. MUSTARD: You also include tar and pitch as causing cancer.

THE WITNESS: Yes.

5 MR. LASKIN: Q. Just to complete at least my questioning on this particular issue, Dr. McCracken, do you recall having had any discussions with your counterpart in claims or with your own staff about using guidelines or using schedule three? In other words, was that a subject that you recall discussing at the time of promulgation of these guidelines? Was there a conscious decision made to go by way of guidelines?

10 THE WITNESS: A. Yes, there is no doubt about it, that there was a conscious decision made that guidelines would be the best vehicle to address ourselves to the lung cancers especially, because of the multi-causal factors that we had to look at.

15 Reference was made at various times during our discussions to schedule three, but we came back to the concept of guidelines serving us better because it would act as a much better tool for the adjudication of the claims.

Q. And even in respect of mesothelioma?

20 A. Even in respect of mesothelioma, because even now I believe a sampling of the world literature indicates that upwards of fifteen percent of mesothelioma cases, there is no definable exposure to asbestos that can be identified.

25 Q. Can you tell me this? In terms of the guidelines, we have heard evidence that they were originally intended for internal use for your adjudicators, and that ultimately they became part of the public literature, as it were. Is that accurate, and if so, can you tell me when it first was that the guidelines became available to the public?

30 A. Well, no I don't think that's really accurate. So far as I am aware, once the guidelines were developed and approved by the corporate board, anyone having an interest in the guidelines were privy to them.

5 A. (cont'd.) I have recollection of, indeed, sending copies of the various guidelines to a number of physicians and other persons that had interest in them, in 1976 - especially those people where the guidelines would have impact.

No, I wouldn't consider that they were...mind you, they were primarily for the use within the Board, and we...but at the same time we didn't consider that they were restricted documents, to my knowledge.

10 Q. But if I were a claimant with a potentially compensable disease, making a claim before the Board back in 1976 or 1977, would I know about the guidelines? Could I get a copy of them?

15 A. If you were a claimant, you probably wouldn't know about the guidelines. But if you asked, I could see no reason, in 1976, why you wouldn't have a copy of the guidelines.

As I say, to my knowledge I never turned anyone down who wanted a copy of the guidelines.

20 DR. MUSTARD: Just your comment about the guidelines were distributed to physicians, etc., in the development of the guidelines did you consult with physicians outside, at anytime, before you finalized them, and did you consult with industry-specific physicians at any time, about the suitability of the guidelines?

25 THE WITNESS: No, we didn't, and the reason for that is that so far as consulting with the general medical profession, we were of the opinion that there were a very limited number of people who had expertise that would be able to pass opinions on what we were attempting to do, to be quite honest, and those people who were in a position to pass an opinion were either partially involved or fully involved in what we were
30 doing, because we had gone to them in seeking out the background data we wanted to develop the original position documents - such

THE WITNESS: (cont'd.) as Dr. Gray and people
in the Ministry of Health and Ministry of Labour who were
involved in the surveillance programs, and so forth and so on.

So far as going to industrial physicians, no, we
did not. Certainly when we were developing the guidelines for lung
cancer in coke oven workers, we made Dr. Charters aware that we
were in the process of developing guidelines, but we did not seek
out any input from him.

The reason that we didn't was that we felt that
if we went in that direction, that indeed we could be
challenged that the guidelines were in part reflecting input
from the group that had a vested interest.

MR. LASKIN: Q. You said you talked to Dr.
Selikoff, at least on one occasion. Did you ever have occasion
to run any of these guidelines by Dr. Selikoff?

THE WITNESS: A. No, but he certainly obtained
copies of the guidelines. It's my recollection, indeed, that
I sent him a copy of either the lung cancer or mesothelioma or
both, but no, we didn't run them by him any more than we ran
them by the general medical profession or industrial physicians,
because we...I was quite concerned that I did not want anyone
to be of the opinion that the guidelines had been contaminated.

Q. I'm not sure I understand that.

A. Well, as I mentioned when I was responding
to Dr. Mustard, that we did not want anyone to be able to accuse
us, rightly or wrongly, that the development of our guidelines
might have been influenced by someone who might have a vested
interest...whatever direction that might be.

Q. And that would include someone in the position
of Dr. Selikoff?

A. It could.

MR. LASKIN: This might be a convenient time,
Mr. Chairman, to take a break?

DR. DUPRE: Thank you, counsel.

MR. LASKIN: Thanks, Dr. McCracken.

Ten or fifteen minutes?

THE INQUIRY RECESSED

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THE INQUIRY RESUMED

DR. DUPRE: May we resume?

Dr. McCracken, I just have on preliminary question.
I want to go back to our dialogue as to the name of the ad hoc
committee, which I think you told me was probably the proper
name for the group that was set up by you and your counterpart
to come up with what became the guidelines.

The only reason I want to go back to it is, since
the Commission has got a report to write, I just want to make
absolutely sure that they are using the right term.

It's just that when Mr. Laskin was asking you a
question about the lung cancer guideline that appears on page
twenty-three of the WCB brief to us, if we go back one page to
page twenty-two...I guess you don't have a copy of the brief...
can you show him page twenty-two, Dr. Mustard?

The opening paragraph on page twenty-two uses
the term 'subcommittee'..."In 1976, the Board established a
subcommittee".

Notwithstanding that, you believe that the interest
remains best served by describing this group as an ad hoc
committee?

THE WITNESS: Yes, that's right, because it really
was not a subcommittee of the management committee or any other
committee, so I would think the correct description would be

THE WITNESS: (cont'd.) an ad hoc committee.

DR. DUPRE: Thank you very much, Dr. McCracken.

Mr. Laskin?

MR. LASKIN: Thank you, Mr. Chairman.

MR. LASKIN: Q. Just coming back to the guidelines for a moment, let me just make sure I have firmly in place the process of adjudication upon which we have had a considerable amount of evidence, but as I understand it, if a claim comes in in relation to an asbestos-induced cancer, that the file will at some stage get to a claims adjudicator who will then refer the matter to Dr. Stewart or Dr. Dyer for a medical opinion?

THE WITNESS: A. Well...

Q. Is my understanding correct?

A. In part, yes.

Actually, the flow of the usual file is that notification will be served that a claim is...has been submitted. It might be submitted by the worker or by his next of kin or by the union representative or whoever.

At that point in time, the documentation rests with the industrial disease section of the claims adjudication branch, and it is a claims document. The file is established and a determination is made as to what information is required from a claim standpoint, so that initially the first part of documentation is generally developed by the claims adjudication people, and they obtain the information that they need - namely, verification that the person indeed did work for a given company, where he worked, and from the knowledge which we hold in our records we have become pretty...the people that develop these claims have become pretty expert in evaluating whether or not a person indeed will be at risk - depending on where he has worked and so on and so on.

5 A. (cont'd.) If the claim comes from a new company that we are not aware of, then at the appropriate moment in time information is obtained from the Ministry of Labour as to any data that they might have and so forth and so on, but initially it is a claim document.

10 When they have developed all the information that they feel they require, then it is referred to either Dr. Stewart or Dr. Dyer, and at that point in time, if the medical information which the claims people obtain is inadequate, then identification is made as to what further documentation is required, what further medical information is required, whether or not specific reports are needed from any of the treating physicians, what hospital records might be deficient, these sorts of things - information from the Ministry of Labour chest surveillance program, and this data is obtained.

15 Then two things may happen. One is, it may go back to the claims with a request for further documentation, or if the documentation appears to be adequate, then the data is referred to the chest advisory committee.

20 Q. Just for a moment looking at the guideline for lung cancer, by way of example, and again I'm sure you are familiar with it, circumstance number one: "There is a clear and adequate history of at least ten years occupational exposure to asbestos".

25 Now, in terms of that circumstance, is that the obligation of the claims adjudicator to gather the necessary information to determine whether there has been ten years occupational exposure?

A. Yes.

30 Q. So before the file would have ever got to Dr. Stewart or Dr. Dyer, the claims adjudicator would have tried to gather together the necessary information to make some assessment as to whether two point one was satisfied or not?

A. That's correct.

Q. And two point two: "There is a minimum interval of ten years between first exposure to asbestos and the appearance of lung cancer".

Now again, would that be the responsibility of the claims adjudicator to gather the information that would be necessary to make an assessment as to whether two point two was satisfied?

A. Usually not, because in that area the time that the diagnosis is made sometimes is very difficult to come by and very often it will be the medical branch, Dr. Stewart and Dr. Dowd...pardon me, Dr. Stewart or Dr....

Q. Dyer.

A. Dyer...who will have to make the further inquiries to establish when the pathological specimen was obtained, when the operation was carried out.

Now mind you, sometimes that information is available and all that Dr. Stewart and Dr. Dyer have to do are to take a look at the data. But by and large, they tend to make that determination.

Q. In terms of the diagnosis as to whether or not it is even a lung cancer, a primary tumor, is that a responsibility of Dr. Stewart or Dr. Dyer, or does a claims adjudicator play some role and try to get information on that?

A. Well, the claims adjudication staff obviously have concerns if the pathological report comes in, and while they are not physicians, they have become very knowledgeable in these things, and if the diagnosis was in, it would indicate that it was a secondary deposit of a malignancy to the lung, then they would indeed make note of this either in a memo or in direct discussion with Dr. Dyer or Dr. Stewart.

But usually, once again, it's a responsibility of the medical staff to attempt, by all means available to them, to

A. (cont'd) verify the diagnosis.

5 Q. So that in terms of the lung cancer guideline, two point one is a responsibility of the claims adjudicator, the verification of the diagnosis and two point two is essentially a responsibility of the medical services people?

A. That is correct.

10 Q. Ultimately, an opinion from the medical services personnel will go back to the claims adjudicator, I take it?

15 A. Yes, that's correct.

Q. Now...and it may be my lawyer's bias...but let me put to you what concerns me, and the concern I have is that the process...the persons involved in establishing these guidelines in the first place...and you have told us who the committee is - claims personnel and medical services personnel - appear to be the very same persons who ultimately have the input into the adjudication of particular cases, whether it be by way of opinion or actual decision.

20 Again, it may be my lawyer's bias, I just wondered - do you perceive that as being a problem, in that the very people sitting on individual cases have been the same people responsible for establishing these criteria in the first place?

25 A. No, I must confess that I don't see that as a problem. I think that what...now, mind you, in the claims area there are people that will handle and adjudicate these claims that have not been members of the ad hoc committee.

In medical services division this is not the case, because we are limited to Dr. Stewart and Dr. Dyer, and they also have the responsibility to supply the medical input into the individual cases.

30 But no, I don't see that as an obstacle and I don't see that as a compromise. As a matter of fact, I visualize this as being a double check, because if the people responsible for

5 A. (cont'd.) agreeing with the claims have at least been responsible that the guidelines are appropriate, and they also have the responsibility to apply the guidelines in individual cases, this gives them an excellent opportunity to make a determination whether the guidelines are fulfilling their requirements and role or not.

10 So it's a double-check mechanism that if they were not fulfilling their requirements, then these people are in an excellent position to come back and say, and tell us that we had better take another look at the guidelines on the basis of experience, because there are discrepancies in the guidelines which are giving them problems.

15 In other words, what I'm saying is that...let us say that the guidelines were entirely too stringent. There is no question in my mind at all that the people responsible for having input into the guidelines, having to use those guidelines in individual cases would soon recognize that indeed they were too stringent and would have complaints about the guidelines - because they are the people who must use them.

20 Q. If one was an individual claimant seeking, for example, compensation for an asbestos-related lung cancer, and that claimant had to rest his case on two point three because he didn't meet two point one and two point two, do you not perceive that that claimant may feel concern that the very persons adjudicating on his individual case have already come to an
25 a priori assessment that his case was not appropriate, to come within what appear to be appropriate guidelines for compensation?

30 A. Well, there is no question in my mind that I'm sure that there have been workers or workers' dependents, spouses, that have indeed wondered who are the people that are adjudicating their claims and whether or not they might have built-in biases, and I don't see that you can ever get away from

A. (cont'd.) that really, no matter how much reassurance these people might be given.

5 All that I can say is that so far as my staff are concerned, and I'm sure that I can speak for the claims staff as well, that they are not there to deny claims - they are there to take a very careful evaluation of all claims in a very unbiased manner, and that's the very reason for the third part of the guideline, so that any cases that do not fit the basic criteria, 10 that they are then in a position to deal with them on an individual basis as all claims were dealt with prior to the development of the guidelines.

15 In other words, nothing has changed as it relates to part three. Part three still allows them to take an individual look at each and every case that does not meet the main criteria in the guidelines, and all I can say is that, yes, if it can be demonstrated that my medical staff are biased against the workers, and yes, if it can be demonstrated that the claims adjudication staff are biased against the workers, then indeed I would have some concerns.

20 But this is not peculiar to the matter of asbestos-related disease. This is the basic responsibility that we at the Board have, and that is that it is absolutely imperative that the staff of the Board take a totally impartial approach to all claims coming before them.

25 Q. Let me just, for the record, Dr. McCracken, make it clear that I am in no way suggesting that either Dr. Stewart or Dr. Dyer were in any way actually biased in their deliberations either on the guidelines or individual cases, and I suppose what I'm really talking about is perceptions, or as we lawyers like to call it, reasonable apprehensions.

30 But you have given me your answer.

DR. MUSTARD: Can I combine a medical background

DR. MUSTARD: (cont'd.) with no legal background, but take your concern?

5 MR. LASKIN: I'm going to give you your LL.B., Dr. Mustard, when these hearings are over.

10 DR. MUSTARD: Let me pose a problem. If I were a claimant caught in this judgement-decision area, if my claim were filed with, let us say, the assistance of Dr. Becklake, who would be regarded as a peer in the system and knowledgeable in this field, as opposed to a claim that came in by my local family physician, not regarded as a peer...obviously this has not occurred, but let's suppose it did occur...surely the claim backed with the supporting documentation of a Dr. Becklake would create a different kind of impact within your system than one that comes from a local family physician - if I am to accept the testimony I've had earlier that there are only a limited number of experts in the field.

15 And I say this because she states very clearly, on this particular subject, "Thus in considering the individual patient with a disease known to be related to asbestos exposure, the wise clinician should avoid regarding any particular exposure as too short, too remote or at too low a level".

20 Can you help me about this sort of problem, that if I were...if you have these two kinds of inputs in that the decision could...well, I guess you can't even help me. I would just like to have your feeling as to how this would impact within your system.

25 THE WITNESS: Well, I believe my interpretation of what Dr. Becklake said was common to almost any medical condition, and that is that if a question is put - is it possible that this could have been caused from this type of exposure - then in a very high percentage of cases the answer has to be yes, because almost anything is possible in the realm of medical science.

THE WITNESS: (cont'd.) What Dr. Becklake is saying, so far as I am concerned is, that yes, there is a possibility -
5 no matter how remote - that there might be some cause-effect relationship, and I don't think we are really arguing against that in our guidelines, and we are certainly not arguing against that in our adjudication of claims.

10 You get into the area of interpretation of benefit of doubt, and this matter was discussed before the select committee to the ombudsman several years ago, and the Board addressed itself to this very question during the deliberations with the select committee to the ombudsman, and the Board does have a definition as it relates to benefit of doubt.

15 In effect, what the Board's policy...and this applies to all cases before the Board...what the Board's policy says, in effect, is that where it is demonstrated that there is a probability, then no question as to benefit of doubt applies, because if a probability exists then the claim...the cause-effect relationship has been established.

20 Where there is a possibility and that might be a reasonable possibility or a moderate possibility or an extremely remote possibility, in any of those gradients, where such a possibility exists and where you have conflicting evidence...and in this case medical evidence...and on the one hand the one part of the medical evidence is coming from a generalist who is not considered an expert in the field, and the other evidence
25 is coming from a specialist who is considered to be an expert in the field - be it epidemiology or pathology or oncology or whatever - then where those evidences are considered to be of different weights, then that evidence that has the greater weight shall prevail.

30 So in other words, if Dr. Becklake were to say, 'in my opinion there is no relation', and the family doctor was to

5 THE WITNESS: (cont'd.) say, 'in my opinion there is', Dr. Becklake's opinion - all evidence being equal - would be weighted in the favor of the expert.

10 Now, in a situation where the evidence is weighted equally - namely, you have two experts and the one expert is saying yes, I think that this could be so, and the other expert is saying no, I do not believe it can be so, where the evidence is weighted equally, then the benefit of doubt shall apply to the worker.

DR. DUPRE: You said, Dr. McCracken, that this is a Board...

THE WITNESS: Policy.

15 DR. DUPRE: Policy, that has been deposited before the select committee on the ombudsman?

THE WITNESS: That is correct.

DR. DUPRE: Was it given to them in written form, or was this an outcome of some oral testimony that was given to them?

20 THE WITNESS: It was flowing from oral testimony, and subsequently was given to the select committee in written form.

DR. DUPRE: I see.

MR. LASKIN: Q. Would we be able to obtain a copy of that policy?

25 THE WITNESS: A. No reason that I can see.

MR. LASKIN: Good.

DR. DUPRE: That would be very useful indeed, Dr. McCracken.

30 MR. LASKIN: Q. I just want to make sure I understand what this policy is. Case number one, the evidence says 'probably there is a cause-and-effect relationship', the principle has no application, compensation flows. Correct?

THE WITNESS: A. That's correct.

5 Q. Case number two, 'there is a possibility of a cause-and-effect relationship, strong, medium or remote', we then look at what the evidence is.

If the evidence on the one side is expert evidence and on the other side is evidence from a nonexpert or nonspecialist, the specialist/expert evidence prevails?

A. That is correct.

10 Q. Who makes the determination as to who is a specialist and who isn't, or who is an expert and who isn't?

A. Well, a determination is generally made on the basis of the individual's training and qualifications.

15 For example, in the matter of a surgical opinion, the person who is holding their fellowship with the Royal College of Surgeons is considered to be a specialist in that particular field. A person who holds their fellowship with the Royal College of Physicians and who has become known as an expert in the treatment of diseases of lungs is considered to be an expert.

20 Q. By whom, though?

A. By his peers.

Q. But in this particular case, in cases before the Board, who makes the determination as to whose evidence is to get greater weight?

25 A. Well, the determination is made based upon the curriculum vitae of the physicians involved.

Q. By whom? By Dr. Stewart, by Dr. Dyer, by the claims adjudicator?

A. Oh, I see. I see what you mean, yes.

30 It would be by the medical personnel reviewing a claim. In that instance it would be Dr. Stewart or Dr. Dyer, and should that claim get into an appeal situation, then the question would have to be addressed in the appeals by the appeal

5 A. (cont'd.) adjudicator, obtaining...or the appeals board...obtaining input from the appropriate medical staff and/or outside consultants.

Q. So that strictly speaking, in this case number two that I've given you, again the principle of reasonable doubt really doesn't have application in the sense that you weigh whose evidence is entitled to greater weight?

10 A. Well, first of all, we...the Board no longer uses the term 'reasonable doubt'. Originally that term was used, but it was felt that the correct terminology should be benefit of doubt rather than benefit of reasonable doubt or reasonable doubt, and it's my recollection that the current policy talks about benefit of doubt, rather than reasonable.

15 Q. So that in these cancer guidelines and asbestos, should I then strike the word 'reasonable' from two point three?

A. Yes, that is correct - as it applies to benefit-of-doubt policy.

20 Q. Is there some substantive significance to the elimination of that word?

A. Well, during the hearings of the select committee to the ombudsman, it is my recollection that considerable concern was raised by some members of the committee about the use of reasonable, and as a result of the concerns which were raised, in the development of the new policy the qualifier 'reasonable' was excluded from the new policy.

25 Q. Was that meant to operate more or less favorably to the worker in individual claims?

A. It was interpreted that that would operate more favorably to the worker.

30 Q. So that...

A. There was concern expressed as to how the term 'reasonable' might be interpreted.

5 Q. So you were looking at any doubt, whether it be reasonable or otherwise?

A. That is correct.

10 Q. And that principle, I take it...well, let me just stick with my case two for a moment, where we talked about the range of possibilities, as I understood it, in which case you would get into weighing the evidence between a specialist and a nonspecialist.

15 In that area, if you have a case where the specialist said yes, there is a possibility of a cause-and-effect relationship, but in my judgement possibility is a remote one; and the generalist says, yes, there is a possibility, and in my judgement it is a very strong possibility that there is a cause-and-effect relationship, what happens? Is the claim denied?

20 A. In that sort of a hypothetical case, yes. In all probability it would be denied, because of the fact that weighting would be placed on the opinion of the person identified as a specialist in that particular field.

25 Q. So the possibility...to exist for compensation, the possibility of the cause-and-effect relationship in the opinion of the expert has to be a, what, a reasonable possibility?

A. No, I don't think so. I don't think so.

Q. If you can as finely tune it as that.

30 A. If you get into another hypothetical situation where you have two experts, reasonably equal in their qualifications, and the one expert were to say yes, I believe there is a cause-effect relationship and it is a reasonable possibility, and the other expert were to say it is an extremely remote possibility, then in a situation like that, that's where

5 A. (cont'd.) the policy of benefit of doubt would apply, and would be considered in those circumstances that the evidence was equally weighted and the benefit of
10 doubt would apply to the worker - namely, that the opinion of the one specialist who said 'I think that it's a reasonable possibility', or 'I think that there is a possibility', versus the other expert saying that it is a remote possibility, under those circumstances, since the evidence would be equally
15 weighted, then merely expressing a difference of opinion - both of them saying yes, there is a possibility, but different gradients - then the benefit of doubt would apply to the worker.

Q. I wonder if you could look at page six of your brief for just a moment.

15 Perhaps one of the Commissioners would be kind enough to show it to you, and this is a page that deals with procedural guidelines for claims adjudicators - asbestosis.

20 You will note in the middle of the page the three requirements for the consideration of allowance, and one of the things which we have observed about those requirements is the absence here, as opposed to lung cancer, mesothelioma, etc., of any statement of the application of the principle of doubt or reasonable doubt, and can I ask you, is that a deliberate omission?

25 A. I was not instrumental in the development of these administrative guidelines, as you can appreciate, but I would say that it was not necessarily a deliberate omission, but it was not considered to be required. The reason it would not be considered to be required is because either a person has asbestosis or they do not have asbestosis, and there is no place for benefit of doubt to be applied.

30 It's a scientific, medical, judgemental decision which must be made, and benefit of doubt is not part of that

A. (cont'd.) application, that I'm aware of.

In other words, either you have the disease or you do not have the disease. If you do not have the disease, well then you have what we have identified as being asbestos fiber dust effect, which may or may not be a precursor of asbestosis in a person who has a history of being at risk.

Q. Even accepting that it is in fact a medical judgement and arguably doctors can disagree on the diagnosis?

A. I am not aware that doctors who are expert in the field have that much disagreement. I think the vast majority of cases, that the diagnosis is...when it's arrived at...is fairly clear, and the majority of people will be in agreement, based upon clinical evidence, pulmonary function studies, clinical assessment where they are available or applicable - clubbing of fingers or whatever - the radiological findings, that the diagnosis can be made or cannot be made.

It's true, I suppose, that there will be situations where there will be a difference of opinion between two radiologists, and in that instance, well, then, one must seek a third opinion or a further opinion.

This is the purpose of, really, the chest advisory committee, is that we are getting input from a number of people who are expert in the field, and so far as I am concerned, when the chest advisory committee makes the decision that a person does or does not have asbestosis, I feel that they have come to a very reliable decision...bearing in mind that the disease in certain people is progressive, and just because the chest advisory committee three years ago says Mr. Jones does not have asbestosis, and this year they say he does have asbestosis, that's no reflection upon the fact that they don't know what they are doing, that they are not experts in their field. What that represents is that the clinical findings,

5 A. (cont'd.) indicators, situation has changed during that intervening period of time, so these people are now in a position where they must reverse their original diagnosis, and that's quite in keeping with the proper clinical approach.

10 DR. MUSTARD: During testimony we've had before this Commission from a wide variety of experts, and during the discussions with Dr. Ritchie and Dr. Gray and Dr. Stewart, we talked about the problem that 'when does the fibrosis really begin in the lungs and when can you detect it by the measurement techniques you have', and we discussed a little bit about some of the newer imaging techniques which are a lot more sensitive and pick up changes in the lung perhaps more readily than you can with current x-ray techniques, and also maybe even
15 sensitivity in pulmonary function assessments may change.

20 As a result of that discussion, I was certainly left with the impression that the diagnosis of asbestosis is really, at the present moment, primarily determined by the technical capability to determine the fibrosis, and if that technical capability improved, the diagnosis could indeed occur at an earlier time.

In other words, the fibrosis may be present, but the diagnosis, clinically, is dependent upon the technology that is available to be applied to it.

25 Now with that, I find a problem about the doubt question that has been raised, because what happens if a group in another area, applying more advanced technology, come in with a diagnosis that somebody does indeed have asbestosis because you've got the pulmonary fibrosis present.

30 How do you judge against the dilemma that you would have, that your panel of experts using your conventional criteria say the individual does not have asbestosis yet, and

DR. MUSTARD: (cont'd.) another group coming in with a little more advanced technology saying you can already show signs which we believe are asbestosis, and we believe this individual has got it?

You now have a question of doubt by two experts, but you have a technology application in which one is a little more sophisticated than the other.

THE WITNESS: Well, to answer the last part first, in that situation I would have some great concern about the people on the chest advisory committee, because I would immediately feel that they were getting out of touch with scientific advances.

In other words, I would hope that that situation would never prevail - that if there is a technical breakthrough that these people will be in the forefront in identifying and utilizing a technical breakthrough, rather than remaining status quo and letting scientific development go past them.

I would hope and expect that indeed this is what would happen, and it's not limited to asbestosis, as you are very well aware.

For instance, in the early diagnosis of bronchogenic carcinoma we now know that in certain instances, by following cellular cytology, that a high suspicion index can be reached, and with selective investigation of the bronchi that very early cases of lung cancer have been identified where the lesion is in situ, where by other methods - x-ray, clinical examination, whatever - the diagnosis would be 'this person has nothing wrong with him, he does not have a bronchogenic carcinoma', but due to the technology, indeed it is demonstrated that he does have an early bronchogenic carcinoma, and I believe that all the scientific community in all of the positions accept the advances in technology, so what I'm saying is that if indeed

5 THE WITNESS: (cont'd.) with the newer scanning mechanisms that a method of evaluating potential cases of asbestosis were developed, and as they are developed, the chest advisory committee will indeed take every advantage of that - just the same way as they have increased the degree of sophistication in their pulmonary function tests that they carry out on our behalf.

10 MR. LASKIN: Q. Can I just place in front of you what I assume is the benefit-of-doubt principle which you were referring to earlier, which comes from the Board Policies and Administrative Directives Manual, under section seventy-nine, headed Directive One - Benefit of Doubt, and ask if you can identify this as such?

15 THE WITNESS: A. Yes, that is the current policy.

Q. And the last paragraph refers to the fact that the principle has no application to an issue that can be decided upon the balance of probabilities?

A. That's correct.

20 Q. And I take it asbestosis, yes or no, is one of those issues?

A. This is my interpretation.

Q. And percentage impairment, if one has asbestosis?

25 A. Well, percentage impairment is a judgemental decision, and what occurs is that the chest advisory committee, as part of their responsibilities, hands down a clinical decision as to the percentage of impairment, and if this is accepted on review by Dr. Stewart or Dr. Dyer, then it is passed to the claims adjudication staff who have a responsibility to equate that into an appropriate pension or monetary award.

30 Now, if in an appeal situation, or if the clinical

5 A. (cont'd.) condition of the patient changes, and it would appear that the percentage is inappropriate or that the worker or the worker's representative feels that it's inappropriate, then in the situation of an appeal, benefit of doubt once again will apply if the evidence submitted is weighted equally.

10 In other words, if as the result of an appeal situation, for instance, or as a result of the individual contacting the Board and saying that in his opinion that his condition has deteriorated, that he would like a review of his permanent disability, then if there is a contest that develops and if the evidence is equally weighted, then the benefit of doubt shall apply to the worker.

15 Usually what happens in these cases is, it's not a contest that develops but rather that we are served notice that the person's condition has deteriorated, or on automatic review the chest advisory committee come to a conclusion that the condition has deteriorated and make the appropriate recommendations for increasing the level of pension, and indeed this is something that Dr. Barth found, that he wondered why the chest advisory committee tended to start out at a low level of permanent
20 impairment and work to a higher level, and the reason for that, in my opinion, is quite obvious - namely, that it represents that there is progression of the disease in those cases, and that the chest advisory committee is acting in a most responsible manner.

25 Q. Just finally on the guidelines, going one step further, I take it it's a matter of record that the guidelines in respect to the asbestos-related diseases have not been altered since their promulgation?

30 A. That is correct. The latest guideline, which has to do with laryngeal carcinoma, we are in the process of taking a very careful look at it right at the present time, but it's

A. (cont'd.) not being looked at as it relates to asbestos, but rather as it relates to exposure from nickel aerosols.

But we revise them as required, and up to the present time we have had no indication that would suggest to us that we need to make major revisions in the current guidelines.

Q. Is there some mechanism within your department for reconsidering these guidelines, from time to time, relooking at them?

A. Yes, there is.

Q. Can you tell us what it is?

A. Well, the mechanism is that...and it's not just limited to the medical services division...but the mechanism is the constant review which goes on with Dr. Stewart, Dr. Dyer and their counterparts in the claims services division.

In other guidelines that we have revised, based upon new scientific evidence that has become available - for instance, in the case of lung cancer in uranium miners - based upon observations made by the staff that the guidelines appear to have deficiencies which they are concerned about - once these have been identified, then the method of addressing ourselves to this is that the deficiencies are discussed by the medical services division people and by the claims services division people, jointly, and their concerns are brought to the attention of the two executive directors.

Invariably when this happens, once we have had a chance to evaluate their concerns, then instructions are issued that a position paper be developed, and recommendations be made as to how the guidelines should be altered.

Q. The working committee that was put together to consider the asbestos guidelines, at the beginning, has it ever been put back together again to take another look at these guidelines in light of the passage of time and the new evidence?

5 A. No, not specifically for the guidelines for lung cancer, mesothelioma or gastrointestinal cancer, but the committee, an ad hoc committee, was put together to re-evaluate the laryngeal carcinoma guidelines.

MR. LASKIN: Yes, Mr. Chairman?

10 DR. DUPRE: Well, just in terms of the whole question of guidelines being kept under review, could I...I am struck by something that Professor Barth points out on page five, twenty-four, that I wanted to ask you about, and maybe Dr. Mustard can share with you his copy of Barth.

15 This is where the guidelines for laryngeal cancer are concerned, and on page five, twenty-four, just above the heading British Columbia and Quebec, the final sentence reads:

"Though the guidelines are used, they are regarded as provisional even now".

Is that statement correct?

THE WITNESS: Yes, it is.

20 DR. DUPRE: Does that imply when you have provisional guidelines that you really are in a situation where you have a guideline that is still in the review process, so that indeed you can speak of a process as very much of a continuing one?

THE WITNESS: Yes. Yes, that is correct.

25 In this situation, when we made the recommendation to the corporate board...and when I say 'we', again it was the executive director, medical services division, and the executive director of claims services division on behalf of our staffs that helped in the development of the guidelines...in the case of a laryngeal carcinoma guideline, we had to inform the board that the scientific data available in the world literature was extremely scanty, and we also had to inform the board that based upon Dr. Miller's case/control study, which was completed for year 30 one only, that we had come to the conclusion that there could be

5 THE WITNESS: (cont'd.) a cause/effect relationship
between exposure to asbestos fiber dust and exposure to nickel
aerosols in the development of laryngeal carcinoma, but we also
served notice, and indeed indicated in our submission to the
board, that the board must consider these to be provisional
guidelines and that we would be reviewing the guidelines as soon
as more scientific evidence became available, and indeed, Dr.
10 Miller concluded his two and a half year case/control study at
the end of last year, and we have been in the process of
re-evaluating these guidelines subsequent to that, and we were
also awaiting the outcome of the McMaster University study that
was commissioned by the joint occupational health and safety
committee at Inco and the United Steel Workers Union, whereby a
study was carried out to determine whether or not there were
15 increased incidents of cancers in the Inco work force, and what
types of cancers, so that we were awaiting the outcome of that
study.

We now have that and we now know what the result
of that study is.

20 DR. DUPRE: And you do have a finalized version
of Miller's report, now?

THE WITNESS: Yes, we do.

25 MR. LASKIN: Q. While you have Professor Barth in
front of you, I wonder if you could just finally go to page nine
point nine, and I don't know whether, Dr. McCracken, you had an
opportunity to read Professor Barth's study before. We have
been throwing particular questions at you, but...

THE WITNESS: A. I read it when we first received
it, yes, and have looked at it periodically since.

30 Q. He is there talking about the guideline-setting
process, and you will notice the first full sentence on page nine
point nine, where he makes the observation:

5 Q. (cont'd.) "However, what does appear highly questionable are the procedures used to develop them. The most surprising of these, at least to me, has been the very narrow circle of persons involved with preparing them. No comments are solicited from the pertinent interest groups".

10 Can I ask you, do you think there is a case to be made for opening up the process, and have you given any consideration to doing so?

15 A. Well, I think that there is no question that if you wish to make a case that indeed you can. The approach that we have used in the guidelines has been to avail ourselves of those persons that we consider to be able to contribute information which we require, and/or who are also knowledgeable and expert in the field.

20 Our difficulty has been in identifying a person who is beyond a specialist, but also is knowledgeable in all the various aspects which are required to assess the problem and develop the guidelines.

25 In other words, you can get a person who is an expert in the field of cellular pathology, but he has absolutely no concept, in many instances, of the science or partial science, if you will, of epidemiology.

30 You can get an epidemiologist who has absolutely no knowledge about the physical or chemical/physical reactions which might lead to a disease process.

35 So this has been our difficulty, to be able to go outside to people that are not directly involved in day-in, day-out Board operations and say, this is our problem and we would appreciate your opinion.

Now, having said that, we do do this, but it has to be in a piecemeal manner, just the same way as we have availed ourselves of Dr. Ritchie and his area of expertise, we have

5 A. (cont'd.) availed ourselves of Dr. Miller and his area of expertise. This is the approach that we have had to take, and the question arises, should we seek opinions from labour, from other worker groups, from management, from other such sources, and as I say, yes, you can develop an argument that very likely or possibly they would have something positive to contribute.

10 However, it has been our approach up to the present time that we...I guess are terribly afraid, in some respects, that by going to outside groups that are generally not considered to be expert in the field, that we might get shouted foul, that we might be accused that one group or another has exerted pressure on our final deliberations, and this has been a great concern that we've had - no question about it at all.

15 In other words, we do not wish labour, for instance, to say, 'ah, yes, but you consulted with the management groups and they, of course, have a very vested interest, and we feel that your conclusions reflect this'...anymore than we want to see it the other way around, that management might say, 'well, you were pressured by the unions to come up with these conclusions'.

20 I certainly agree that we could obtain information from these groups. No question about it all.

25 But up to the present time, we have limited ourselves to seeking scientific input from those people that are considered to be expert in the fields, and I say fields because we have had to shop around to get the input that we require.

Q. When you say...who do you mean when you say 'we'?

A. We? I mean Dr. Stewart, Dr. Dowd, myself, primarily.

30 Q. And the process you have just told us about, does that fairly reflect your future plans in terms of the development of more guidelines or the revision of guidelines

5 Q. (cont'd.) already in place, and is there any consideration being given to changing the process, or are you likely to carry on, on your present course?

10 A. I think, myself, that we have a pretty open mind on it, and if indeed when we develop a new guideline...as we do each time...we always discuss the matter - have we anything to gain, will it be of some assistance to us in our deliberations in this difficult area to consult with people who are knowledgeable in occupational medicine in this field that are employed or work on behalf of the Steel Company of Canada, for instance, or Dofasco, or whatever, should we consult with the unions on this - and I think that we have a pretty open mind on it.

15 The only thing is, up to the present time that each time that we have discussed it we have come to the conclusion that no, we feel that we should develop the guidelines as a guideline developed by the Board, which will be above challenge that outside influence has been used in molding the guidelines.

20 Now, sure, I quite agree that you can look at it from the other angle and say, well, possibly the guidelines would be helped if you had input from these other groups, and this is why we must keep an open mind to it. No question about it at all.

25 So, no, I don't think...to answer your question...I don't think that we will necessarily continue to do exactly what we have done in the past. If we can identify that there is a reason to involve outside groups, then we will.

30 However, having said that we must be very cautious when we do that, namely that I would think it would be terribly wrong for us to involve only one group.

For instance, I would be absolutely against having input to a new set of guidelines from management. It would have to be from management and from labour, or from the workers or their representatives.

5 A. (cont'd.) In other words, it must be an equitable type of input, because otherwise I would think that we would be getting into very dangerous ground.

DR. DUPRE: Can I pursue this for a moment, counsel?

MR. LASKIN: By all means, Mr. Chairman.

DR. DUPRE: There are two ways of thinking about openness in guidelines, that occurs.

10 One way is the way that Professor Barth seems to point to, which would be to actually open up, to inputs from different groups, the guidelines at the stage of the guideline-making process.

15 But there is another avenue to openness, which could be called ex post openness. That is to say, a process that assures that once a guideline, which maybe has been made inhouse or by specialists, is made, it is first of all made part of public knowledge, and secondly, open to question by responsible individuals.

20 Now, what I would like to ask you, Dr. McCracken, is the extent to which the select committee on the ombudsman, perhaps, has come in recent years to give us the second kind of ex post openness, does that committee receive your guidelines as they are formulated...or I should say, after they have been formulated...and has it been your experience that the select committee will question you or some of your senior colleagues from time to time, year to year, on these guidelines?

25 THE WITNESS: Well, I can't speak for the select committee to the ombudsman. To my knowledge I don't believe that any of the guidelines have ever been before the select committee for purposes of discussion, but each year I, and other members of the Board, appear before the resources committee...or in certain years, select committee...on the Workmen's Compensation Board.

30 DR. DUPRE: It certainly is the select committee on

DR. DUPRE: (cont'd.) the Workmen's Compensation Board, and in other years the standing resources committee?

THE WITNESS: Yes, that is correct.

Since 1975, to my recollection, I cannot recollect a situation where the members of that committee have discussed the contents of any of the guidelines per se. They have discussed the acceptance or rejection of cases of certain types of cancer, and they have also discussed how silicosis cases have been handled, things like that, but to my recollection they have never discussed the contents of the guidelines per se.

Now, I might add that post hoc that we have had a policy where we would distribute copies of the guidelines to those parties that indeed well might have interest in them - the appropriate health representatives to unions, and guidelines that pertain to specific industry, for instance, the guidelines for lung cancer in foundry industries. We sent copies of those guidelines to the Canadian Foundry Association and to the foundries that had been involved in the study, and to the unions who were involved in the study, and any requests that we received, it's a public document and they received the guidelines.

With meetings that we have had with the unions, from time to time, and on several occasions in meetings that we have had with some people from the employers, certain parts of the guidelines have been brought forward for discussion, and we have listened to their concerns and we have usually clarified the interpretation of the guidelines to their satisfaction.

By and large, I must say that the companies involved that have impact against the guidelines, by and large they have been of the opinion that the guidelines, so far as they are concerned, are serving a good purpose, and they have not criticized the guidelines.

So far as the unions are concerned, again they have

THE WITNESS: (cont'd.) really not criticized the guidelines.

5 There was one instance with our first guideline of lung cancer in uranium miners where the guideline was criticized, but it was criticized on the basis that part of the guideline would tend to indicate that if the miner did not exceed one hundred and twenty working level months, that he had nothing to worry about and would never get a lung cancer, and of course this was a misinterpretation of the guideline and we attempted to explain to them that this was not the case and indeed we did have lung cancers which we had allowed where the accumulative radiation was less than a hundred and twenty working level months.

10 As a result of those discussions, in part, when we revised the guidelines for lung cancer in uranium miners, we deleted that one aspect of the guideline relative to a specific level or working level months of cumulative radiation. We indicated that radiation exposure was one of the factors that we must still consider, but we did not have any specific figure that we felt we could use.

15 DR. DUPRE: With respect to select committees of the Legislature, I think in your earlier testimony you mentioned that the Board policy to remove the word 'reasonable' from the principle of reasonable doubt came about as a result of some dialogue with the select committee of the Legislature?

20 THE WITNESS: Select committee on the ombudsman, yes.

25 DR. DUPRE: This was the select committee on the ombudsman?

THE WITNESS: Yes, yes.

30 DR. DUPRE: Now, the principle of reasonable doubt, of course, is a set of words that appears in a number of those guidelines, and I was just wondering if this dialogue had gotten

5 DR. DUPRE: (cont'd.) going in the committee because they were looking at some of your guidelines where those words appear?

10 THE WITNESS: No. The question was brought up in the select committee to the ombudsman when they were examining some specific cases, and to my recollection none of them related to a malignancy or to asbestosis. They were traumatic types of cases, where benefit of reasonable doubt, as it was known as then, had been applied, and they were challenging the interpretation of benefit of reasonable doubt.

15 As a result of the discussions, as I mentioned, it was considered that reasonable had a connotation of possible abuse, and the board was most ready to delete the term reasonable and to address themselves to benefit of doubt per se, and as a result of those deliberations, the current Board policy on benefit of doubt now exists.

20 DR. DUPRE: Dr. McCracken, I listened very closely to what you had to say in terms of the way you react to what Professor Barth writes about the possible desirability of opening up the process. I took it from what you said that you have an open mind on it, but I also took your reservations as reservations that, frankly, I would not be disposed to take lightly, in the sense that one could, I think...or at least if one was deliberating about this matter...give some attention to the apprehensions that you express, I suppose, in the sense that if you open up the guideline-setting process to submissions, say from management and labour, you may run the risk...I don't know how great a risk it is, but I'm willing to entertain your apprehension here...you may run the risk of confusing a scientific judgement with an arbitration kind of judgement.

30 I take your point for what it's worth, and I would just like to ask if you have any reflections concerning the merits

5 DR. DUPRE: (cont'd.) or otherwise of opening up
the process in this different kind of ex post or post hoc way,
namely through a situation whereby there would be a forum, and
a forum made up of elected legislators is not a bad one at all
from any of a number of public administrations standards, that
there would be a forum of legislators who, of course, would have
to get new guidelines as they come out, and then, of course, have
10 the opportunity to satisfy themselves about the manner in which
the specialist knowledge that was required was assembled and
translated into the guidelines that are before them.

Do you have any reacton to this kind of alternative
way of perhaps opening up the process?

15 THE WITNESS: Well, first of all, I really agree with
you when you identify that part of my reservation - in fact, a
significant amount of my reservation - is that 'are we contaminating
guidelines developed upon scientific principles with guidelines
that are developed in part upon political decisions'.

DR. DUPRE: Or simply on principles of conciliation,
if you will.

20 THE WITNESS: Correct.

It has always been my approach that the purpose of
guidelines are to give the appropriate guidance, based upon the
best scientific principles and advice and information that we have
available to us, to the Board's staff.

25 If, in the wisdom of our political masters, these
guidelines are not acceptable, I really question that it should
be achieved by altering the guidelines to a nonscientific political
document.

I feel that other avenues must be looked at. This
is my personal opinion.

30 I am much more comfortable with guidelines that
are based upon the best scientific advice available, and if this

5 THE WITNESS: (cont'd.) creates problems that are addressed, and the problems are not on the basis of faulty scientific data, then I really feel that those problems must be addressed elsewhere in the system.

10 I suppose a good example of that is the fluorospar mining operations in Newfoundland, where a political decision was made some years ago, I understand, that anyone employed there who developed any malignancy of any sort in any target organ would have the claim allowed.

15 Of course, this is not based upon any scientific data whatsoever. It was a political decision which was made at that time, as I understand it, and this is something that I really would not like to see happen to our guidelines. I feel that we should develop our guidelines on sound scientific principles, and that if there are to be changes made, that they should be made somewhere else within the structure as it relates to how these claims might be handled.

20 DR. DUPRE: Granting your philosophy about the importance of maintaining the scientific integrity of so-called scientific or medical, perhaps, is a less-charitable term, guidelines, granting your philosophy about the importance of maintaining the integrity of the science, it does...well, in my view, since we can have a little philosophical dialogue here...if I grant that point, there remains a very strong public interest in, first of all, knowing what the guidelines are and secondly, in having an opportunity for responsible individuals to satisfy themselves that these so-called scientific guidelines were indeed achieved through the input of the best scientific advice possible.

30 Now, to the extent that philosophically I would have to say that the public interest needs to be served here, the proscription that seems to flow out, in my mind, for the sake

5 DR. DUPRE: (cont'd.) of entertaining it for a moment,
is a situation where not only you, Dr. McCracken, and some of your
colleagues at the Board, but Dr. Ritchie or Dr. Gray...incidentally,
very much as they have done here...but might well be people who,
whenever a new guideline has come out, that they are the ones
who have been involved in it, would be prepared to appear before
a select committee of the Legislature and explain to them how
they got there.

10 Does that make sense?

15 THE WITNESS: Yes, it does. I really can't see
anything wrong with that, but so far as I am concerned I am sure
that if the select committee on the Workmen's Compensation Board
were to address themselves to any of our guidelines and request
information, that if indeed the information that could be supplied
might come from someone such as Dr. Gray, I'm sure that Dr. Gray
would, indeed, be prepared to appear before such a committee.

20 Certainly we would do our best to discuss the
guidelines with the members of that committee. There is no
reason why we shouldn't. I think it's important, if the issue
is raised, that they be given an adequate explanation.

25 The question, of course, is, as you mentioned,
to satisfy the public that the guidelines are based upon the best
available scientific data, and that they should be evaluated by
appropriate people, I believe you said who are qualified to do
so.

30 I, too, would be in favor of that. Our experience
has been that it is extremely difficult to come up with these
people who are appropriately qualified to carry out such an
evaluation, and any time that such a person might be identified
to us, I'm sure that we would welcome that person's input, even
as a post hoc, because as I have mentioned, the guidelines are
there to be constantly reviewed and to be revised when we have

5 THE WITNESS: (cont'd.) the information requiring revision, and indeed we have revised a number of our guidelines since they were first developed in 1976.

10 DR. DUPRE: I guess when I am talking about who is involved in the reviewing, of course, Dr. McCracken, I'm not thinking of an expert at all. I am thinking of members of a select committee of the Legislature, or for that matter, a standing committee, who, of course, would have the guidelines in front of them and simply have an opportunity to question you and yours about who was involved in preparing them and what kinds of scientific consideration went into them, whether, to the best of your knowledge, there is scientific controversy concerning some of the points involved, or there is not, so on and so forth.

15 But these are elected members of the Legislature that I'm thinking about.

20 THE WITNESS: Well, again, certainly so far as I'm concerned, I'm sure that the Board, insofar as I am concerned, that I would be quite prepared to discuss our guidelines with MPP's on a select committee...no question about that at all. There is no reason why we shouldn't, so far as I'm concerned. No reason at all.

25 DR. DUPRE: Thank you. I was just quite interested in getting your views, because I appreciate the frankness with which you discussed the questions that Professor Barth raised in your mind about opening it up in the other direction.

Sorry, counsel.

MR. LASKIN: No, that's fine. Mr. Chairman.

30 MR. LASKIN: Q. Just as a final question on this issue, Dr. McCracken, do you think there is any case on the scientific side for a committee, not unlike the advisory committee on occupational chest disease, but an advisory committee of

5 Q. (cont'd.) scientists, medical people, entrusted with giving recommendations on guidelines, which might be more permanent in nature...and I say permanent, not ad hoc and struck for the particular point in time, but there with some continuing mandate to look at the guidelines that are in place, in light of ongoing scientific research and so on?

10 THE WITNESS: A. Well, it's certainly a very interesting thought. The problem that...and believe me, I have thought about this on any number of occasions...the problem that I identify is, in turn, to identify those persons who might serve on such an ongoing committee.

15 It's much easier to identify those specialists in certain very narrow fields that can function on an ad hoc basis. For instance, I have identified people who have indicated that they would be prepared to serve, on request, to function as the special committee to take a look at any problems we might encounter in the field of lung cancer claims related to alphasradiation, primarily in uranium miners, but it was not easy to get such a committee.

20 As a matter of fact, it took me half a year before I could really nail the people down, because I had to get a person who was knowledgeable in the natural history of the disease and a well-qualified surgeon, I had to get a person who was knowledgeable in the field of the epidemiology of the disease, and I had to get a person who was knowledgeable in radiation physics.

25 Now, you could take those three people and say this will be part of an initial committee, but when you get outside of the field of radiation, for instance, the radiation physicist, if he were a permanent member of that team, would be spending most of his time doing nothing and contributing nothing.

30 This is my problem, there is no question about it is, that it's such a specialized area that you have to put it together

5 A. (cont'd.) in bits and pieces, and I would dearly love to be able to identify a group of people who would make a commitment of the time to sit down and who would be with us on a reasonably consistent basis, so that the membership of a committee would not be a floating membership, to indeed be a source that we could go to and say, now, here is what we are proposing to do, would you care to take a look at this, or here is what we have already done, would you care to take a look at this.

10 But up to the present time, I must confess that I have met with defeat in trying to identify the people who would be on such a committee.

15 I can get certain numbers at certain times, but I haven't been able to identify all the players, and whether I ever will or not, I don't know.

MR. LASKIN: Thanks, Dr. McCracken.

At this point, Mr. Chairman, I have a personal problem in that I have a personal commitment that I have to fulfill. The Commission has done admirably, so that..could I be permitted to withdraw with...

20 DR. DUPRE: Yes. When will we expect your return, counsel, about three o'clock or so?

MR. LASKIN: Yes, but I virtually...there are a couple of areas of which you are aware that still have to be explored, but other than that I certainly finished this particular subject.

25 DR. DUPRE: At the moment, counsel, I would just be inclined to briefly open up another area of questioning and then break at one, resume at two-fifteen, and go to the batting order if I can be presented with one at that time.

MR. LASKIN: That's fine, Mr. Chairman. Thank you very much.

30 MR. EDWARDS: Mr. Chairman, perhaps I could raise

5 MR. EDWARDS: (cont'd.) a concern. I understand Mr. John McDonald is going to be available around two o'clock. Is it the intention of the Commission to continue with Dr. McCracken, or would you wish to start with Mr. McDonald?

DR. DUPRE: We are certainly going to be with Dr. McCracken for a while this afternoon. Would that be...a good part of that depends on the batting order. Do you have a...

10 MR. McCOMBIE: As far as questions for Dr. McCracken? I don't expect to be very long myself.

MR. STARKMAN: I would just be brief.

DR. DUPRE: Okay.

Well, perhaps it might be advisable to as Mr. McDonald to come about three-thirty.

15 MR. EDWARDS: Fine.

DR. DUPRE: That won't cut into the afternoon that much, and if we get through before three, as I told my counsel, it's not necessarily a mortal sin to take a half hour break.

So that would be fine.

20 MR. LASKIN: You keep saying it, Mr. Chairman, but it never happens.

DR. DUPRE: I know.

Dr. McCracken, just before we break, there is something that I wanted to ask you, that occurred to me very early on, simply describing your initial appointment at the Board in 1975.

25 At that time, as I understood you, you were made the executive director of both the medical services division and the vocational rehabilitation division, or was it in fact at the time one division?

30 THE WITNESS: At that time, the task force had completed their deliberations and the decision had been made that vocational rehabilitation would be amalgamated with medical rehabilitation, and vocational rehabilitation was a branch under

THE WITNESS: (cont'd.) the umbrella of rehabilitation services division. That was the division as it was known as in 1975, having been established in 1974, following the task force deliberations.

Then as vocational rehabilitation grew and assumed its level of responsibility, it became pretty obvious that they should be a separate division working in close harmony with the medical services division.

DR. DUPRE: When did they become a separate division?
THE WITNESS: In 1978.
DR. DUPRE: In 1978.

However...well, does that mean that between 1975 and 1978, you were executive director of both medical services and...
THE WITNESS: The vocational rehabilitation?
DR. DUPRE: Vocational rehabilitation?

THE WITNESS: Yes, that's correct. During that interval of time my own responsibility was our hospital and rehabilitation center, the medical branch which has a responsibility of paying all monies for treatment and services rendered, a splinter from that - the medical aid consultant group - and vocational rehabilitation branch as it was then known.

DR. DUPRE: Right. And, of course, I gather from our organizational chart that of course you remain in charge of the hospital and rehabilitation center?

THE WITNESS: That is correct.
DR. DUPRE: I take it then that...I take it that this means that at the time the special rehabilitation assistance program with Johns-Manville was started in 1976, that you were the relevant executive director?

THE WITNESS: That is correct.
DR. DUPRE: In charge of that. Did you have an

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THE WITNESS: That is correct.

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rehabilitation center, the medical branch that we have discussed,

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THE WITNESS: The vocational rehabilitation?

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1975, having been established in 1974, following the task force

services division. That was the division as it was known as in

THE WITNESS: (cont'd.) the umbrella of rehabilitation

McCracken, in-ch

Similarly, there were workers that wanted to avail themselves of the program, but they did not qualify to enter the program because upon investigating the situation it was determined that they were no longer at risk - they might have retired, or

themselves of the program. whatever reason or another, that they did not wish to avail

there were a significant number of the workers that felt, for or not the worker elected to participate in the program, and indeed them being the decision must be left with the worker as to whether against a full participation in the program - not the least of

borne in mind that there were a lot of circumstances that mitigated that the purpose of the program was achieved, but it must be

I really must take exception to that, because I feel fully successful.

might have been expected, that the program did not appear to be all people were not involved in the program, or as many as what deficient, and it might be that he feels it was deficient because He indicates, in my opinion, that the program was

assistance program was implemented. problems that existed at the time of the special rehabilitation Professor Barth really was not able to come to grips with the THE WITNESS: It was my interpretation that

problems it had? it fairly reflected your own observations of that program and the DR. DUPRE: Did you consider that, on balance, that

THE WITNESS: Yes, I did.

various problems it encountered? DR. DUPRE: ...and what he has to say about the

THE WITNESS: Yes, I did.

description of the program... eight in Professor Barth's study, with respect to his general DR. DUPRE: (cont'd.) opportunity to look at chapter

THE WITNESS: (cont'd.) I left the employment, or been moved to an area where no longer it was identified as being an area of risk in the Johns-Manville operations.

There were people that started the program and dropped out of the program, so that if you look at the program without knowing the background, and without appreciating that this was an offshoot from the special rehabilitation program which was developed for the uranium miners, indeed you could come to the conclusion that something was lacking in the program, but I think it was the very nature of the program that meant from day one that we were not going to be able to get all the people into the program that should be in, for very valid reasons, that we were not going to be able to rehabilitate everyone.

For instance, one of the criteria that the vocational rehabilitation had to grapple with was the very definite requirement that a determination must be made as to whether or not the individual had the potential capabilities for retraining, so that they could be rehabilitated into another type of occupation.

This was particularly appropos to the Johns-Manville situation, unlike the mining operation where you had a little bit of latitude in that the person could always be put on some sort of surface employment, by and large.

DR. DUPRE: Professor Barth does note that difficulty.

THE WITNESS: That's right. And that was a very real difficulty. There is no question about it at all.

DR. DUPRE: Let me just switch to one other area, if I might, Dr. McCracken. It relates to Outreach more generally, I think. It has compensation implications.

It is this: You are aware, as I am, of Dr. Selikoff's ongoing and indeed continuing work on a large cohort

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DR. DUPRE: (cont'd.) of insulation workers.

THE WITNESS: Yes.

5 DR. DUPRE: Which, of course, includes within its number an employee population from Ontario.

THE WITNESS: Yes, correct.

10 DR. DUPRE: Since I gather from your earlier testimony you know Dr. Selikoff, have communicated with him from time to time, is this study something that has given the Board some feel for the incidence of disease that is potentially compensable out there? Have you been able to use the results of that study in such a way that it becomes a kind of a check on the extent to which your volume of claims correlates with what Dr. Selikoff is finding in this group?

15 THE WITNESS: Well, it's very difficult, really, to compare the group of claims that the Ontario Board has with the cohort that Dr. Selikoff has.

20 For one thing, for instance, some of our claims would never be identified in a cohort similar to Dr. Selikoff's, because he is basing his study on death records and we have an ever-increasing number of claims that are not fatal claims, but that are surviving claims, so that's one factor right there.

25 I think that the other factor is to attempt to evaluate what role asbestos exposure has been playing in any increased incidence in cancers, and I feel that rather than a cohort study that the best way that has been used to approach that, so far as I am concerned, has been the overall epidemiological evaluation such as the one carried out recently by Peto and Doll, at the request of the U.S. Congress, where they indeed did identify and in their report submitted to Congress they are of the opinion that four percent of all cancer deaths may be related
30 to occupational factors, and of that group they further estimate that between one and two percent of cancer deaths may be related

THE WITNESS: (cont'd.) to asbestos exposure in that group - that is, of the four percent, one to two percent could be.

Looking at our cases, the ratio of asbestos claims... and I'm talking about claims for malignancies now, not asbestosis... looking at the Ontario claims and looking at our overall claims for malignancy, our ratio appears to be fitting very well with Peto and Doll - namely that around about thirty percent of our total of claims relate to persons that have had their claims dealt with on the basis of asbestos exposure versus coal tar, pitch volatiles, and radiation, and arsenic, and nickel aerosols.

So that our data that we have on our actual experience fits very well with the percentage figures that Peto and Doll have come up with, that we appear to be identifying the correct proportion of asbestos malignancy claims.

DR. DUPRE: Dr. Mustard?

DR. MUSTARD: You might like to comment: If you apply the four percent figure to the cancer deaths in Ontario, and then look at the number of claims you compensate for cancer, I believe the figure turns out to be approximately six hundred cancer deaths each year would be due to occupational exposure, if you use the Doll and Peto argument, but the number of cancers you compensate is about one-tenth that...I think the figure comes out to be about sixty, about what your compensation awards are over the period of time, and the Doll and Peto calculation for Ontario would be six hundred.

So a question comes up, does that mean we just have less industrial exposure in Ontario, and that average doesn't calculate, or does that mean we are missing some?

THE WITNESS: Well, I don't think I can answer the question whether we have less industrial exposure or not. I really can't express any opinion on that.

5 THE WITNESS: (cont'd.) I think that if you look
at the cancer statistics for Ontario, that if you adjust the
cancer statistics for age and sex, that that narrows down the
difference considerably between the number of cases that we
are allowing year in and year out, with fluctuations, and
the Ontario statistics, because still the majority of our cancers
are related to the male who is exposed at risk, rather than
10 the female who is exposed at risk, by the very nature of selection
in the work force, nothing else.

So that I believe that...and indeed, Dr. Chovil,
in attempting to evaluate this, concludes that in all probability
we were identifying the vast majority of those cancers that are
related to occupational exposure.

15 Now, we are always going to have surprises, and
an example of a surprise was the study that was done at Dofasco
where it was demonstrated that twenty-five, thirty years ago
something was going on that gave rise to an increased incidence
of lung cancers in foundry workers, and this is the type of
surprise that we must expect in the future.

20 I must say that I do not predict any epidemic of
cancer, either in any specific area or generally. I feel that,
as a matter of fact, that while the effects of twenty to thirty
years ago will continue to be felt for the next ten to fifteen
years at least, that beyond that there will probably be a
significant decline of the occupationally-related cancers
25 because the hygiene in the workplace has improved so significantly
in the past ten or fifteen years.

That is certainly bound to have an effect, so far
as I can determine.

30 But no, I agree that on the one hand we may be
missing some cancers - a case of a person who has worked in
Ontario who has maybe moved out of the country or out of the province,

5 THE WITNESS: (cont'd.) and who develops a lung cancer, and that lung cancer, if a claim were filed, indeed we might conclude that there was a cause-effect relationship, and it would be an allowable claim. No question about it, that these can happen.

10 But on the other hand, I am also satisfied, and so is Dr. Chovil in his study on it, that in all probability our guidelines are such and our approach is such that we are allowing more claims for those claims that are submitted to us than what we should be allowing, so I think that the one probably cancels the other - that the ones that are not being brought to our attention, numbers are being compensated for by the numbers that we are allowing.

15 DR. DUPRE: Well, this is an appropriate point at which to break. We will rise, then, until two-fifteen, Miss Kahn?

MISS KAHN: I should just perhaps bring to your attention, Mr. Chairman, that I now contacted John McDonald. He apparently has some obligations that would require him to leave the Commission by four-ten.

20 I, therefore, took the liberty of suggesting, perhaps, that he arrive here at three.

DR. DUPRE: At three? Fine.

THE INQUIRY RECESSED

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25 THE INQUIRY RESUMED

DR. DUPRE: May we reconvene? Can I have a leadoff?
Mr. McCombie?

CROSS-EXAMINATION BY MR. McCOMBIE

30 Q. Dr. McCracken, I would just like to begin by going over a couple of things that Mr. Laskin was asking you, and

Q. (cont'd.) getting a couple of bits of clarification.

5 In particular on the benefit-of-doubt policy, and
you were discussing with him the question of benefit of doubt, and
as I understood your answers, insofar as asbestosis claims, you
didn't really see how that would apply in most asbestosis claims.
Is that correct?

10 A. Yes, that's correct. To be absolutely clear
on it, there has been a considerable amount of confusion, in my
opinion and in the opinion of other people, about where benefit
of doubt should be applied.

15 There has never been any question about that in my
mind at all, nor in the minds of senior people at the Board. That
is that benefit of doubt applies and is applied by the claims
services division staff - not by the medical services division.

What I'm saying is that in the adjudication of a
claim is where the benefit of doubt policy applies.

20 In the medical evaluation of a claim, benefit of
doubt should not apply because what we are doing is, we are
attempting to establish on a scientific basis a cause-effect
relationship, and on a scientific basis, so far as I am concerned,
you do not apply benefit of doubt. What you do is, you apply
the best available scientific data and the best available opinion
that you can obtain.

25 So on that basis I think that it must be considered
that benefit of doubt should not be used in the medical
evaluation of the problem, but rather that what we are doing is,
we are giving the best available medical opinion, and thereafter
then benefit of doubt will apply in the adjudication of a claim -
such as medical evidence that is equally weighted.

30 Q. Would it fair, then, to summarize it as saying
that benefit of doubt, from your perspective, would be more an
administrative or legal...

A. That's correct.

Q. ...tool, rather than a medical one?

A. That is correct.

Q. Now, there's several possible applications that Mr. Laskin put forward, and one of the things that interests me is where you do have medical evidence that is conflicting, that comes to the adjudicator, let's say, and I gather that your answer was that more credence would be placed on medical evidence that would come from an expert in the field, is that correct?

A. Yes, that's correct.

Q. Would that...I guess the question arises, then, how one defines expert - whether you are defining in a strict academic or licenced role by the College of Physicians and Surgeons or whatever - or whether there are some other criteria that are used to define expert. I guess what I'm getting at, the reason I'm raising this is that in a lot of the cases that we have been dealing with at this Commission, we have been dealing with the medical opinions of Drs. Dyer and Stewart, who from our understanding, do not have licencing qualification that other people might have.

I'm just wondering if, to take again a hypothetical example, you would see Dr. Stewart or Dr. Dyer's qualifications equal to those of a respirologist from outside the Board?

A. Well, it really doesn't work in that aspect - namely, that Dr. Stewart and Dr. Dyer do not place themselves in a competitive position with an outside medical opinion.

The role of Dr. Stewart and Dr. Dyer are the same as the role of any of the other physicians on the Board in the medical branch, and that is to evaluate by all the data in the file, including medical information, hospital records, etc., by actual examination where it is felt that this will be of assistance, as to the preponderance of opinion and medical evidence relative

A. (cont'd.) to the diagnosis and relative to the cause-effect relationship.

5 In other words, what I'm saying is that while Dr. Dyer and Dr. Stewart do not hold their fellowship in the Royal College of Physicians degree, and they are not in the practice of respirology, and they are not experts in the field of oncology, nonetheless they have developed - and this is in answer to the first part of your question - they have developed a very sophisticated degree of expertise in a very narrow field of activity through their exposure to all the data that comes across their desk, and through the exposure to all of the cases that they have dealt with.

10 So while they do not have those qualifications, they are indeed considered - not only by ourselves, but they are considered by the outside medical community as being experts in that particular field of activity - bearing in mind that there is no such specific qualification as an expert in the field of compensation medicine, if you will.

15 So that yes, there are two definitions of an expert. One is an expert who is qualified through training and through the writing and passing of examinations to be identified as a specialist in a given field, such as myself in surgery, such as Dr. Cameron Gray in the field of internal medicine with his special interests in respirology and disease of the chest; and there are the other experts that become experts because they have confined themselves to a narrow, specialized type of field.

20 A good example of that is occupational medicine itself, where up to the present time there has been no recognized fellowship degree in occupational medicine, and the people interested in occupational medicine are pushing for this degree because they feel that they have developed a field of specialization which warrants this, and the Royal College is indeed looking at

5 A. (cont'd.) She also spent some number of months out at our hospital and rehabilitation center, where she was involved in the actual practice of rehabilitation medicine and carried a case load of injured workers who were out there undergoing assessment and treatment, and again the senior staff out there supervised her activities until they were satisfied that she was able to assume a full case load.

10 Then when she finished that basic or initial training, then she returned to the area of industrial diseases and currently she is still being exposed to the expertise that has been developed by the other industrial disease consultant who has been with the Board for many years.

15 So it's a composite type of training, and over and above that it's my policy that members of my medical staff shall attend appropriate medical seminars, meetings, presentations, post-graduate courses that are apropos to the type of work that they are doing, and Dr....both Dr. Dyer and Dr. Stewart have indeed been attending such seminars and courses.

20 Q. I would assume this would be the case for all medical staff coming on board at the present Board?

A. That's correct.

25 Q. Another question that Mr. Laskin asked you this morning, and I would just like a very brief followup on this, he was asking you whether or not you saw any conflict between those that are setting the guidelines being in many cases those that are involved in the adjudication or recommendations on adjudication for cases, and you indicated that as far as you were concerned it wasn't a problem - in fact in some ways it was of benefit.

30 I'm just wondering if you see any conflict at all when these kind of cases go through the appeal system and we often see the same people making recommendations all the way up -

5 Q. (cont'd.) that is that one doctor gives a recommendation to the appeals adjudicator, that decision is then appealed to an appeals adjudicator who sends it back to the same doctor, and so forth, which is our understanding of what will often happen in an asbestos case, and I'm wondering if you see any conflict at all in that, or any perception of conflict.

10 A. Well, I wouldn't perceive that as a conflict, but I would perceive it as the same individual grappling with the same problems and trying to determine whether or not he should come to the same conclusions from a medical standpoint.

15 To overcome that, it's our policy that for instance if Dr. Dyer has been involved in a given claim and it gets into an appeal situation, Dr. Stewart is a person that the file is referred to, and vice versa.

20 If it goes beyond that, then not infrequently this is where Dr. Gray, who is also acting as a part-time consultant for the Board, will then become involved and it will be his responsibility to introduce his opinion and of course this is a separate function that Dr. Gray has from the chest advisory committee, in that...and it's primarily with the cancer claims where they don't come before the chest advisory committee in any event...and he acts as another consultant.

25 Beyond that, then our other course or avenue is indeed to obtain the opinion of another independent, outside consultant, which either Dr. Dyer or Dr. Stewart can use as a base for new information, new opinions, new evidence.

30 Q. Can I just make sure I have this straight? Did you say that if, for example, Dr. Dyer were involved in the initial adjudication and there were an appeal on that particular claim, that it would automatically go to Dr. Stewart?

A. Not automatically, but invariably this is the

5 A. (cont'd.) direction that it is directed, namely that both Dr. Stewart and Dr. Dyer...unless they are not available and there is some urgency...but under ordinary circumstances, if Dr. Dyer has dealt with a claim initially, then Dr. Stewart will deal with the claim when it returns in an appeal environment.

Q. So there is an attempt made to...

10 A. Very definitely. In other words, the name of the game is to obtain the widest base of medical opinion that we possibly can get.

15 Q. Another area that was raised this morning which, for myself anyway, has been a constant source of misunderstanding, it seems to me, is the whole question of who is assessing what, and I believe in your direct examination this morning you indicated that the relationship with the ACOCD, from your point of view, you wanted to make it very clear that they were only going to be assessing the clinical impairment, and that the role of assigning a permanent disability rating is ultimately that of the pensions adjudicator, or the claims
20 adjudicator in the case of the ID and D section. Is that correct?

A. That is correct.

Q. So that you do differentiate between the clinical impairment rating and the permanent disability award, as being two not necessarily similar things? Is that correct?

25 A. Yes, that's right. There is a distinction.

Now, mind you, having said that, in a very high percentage of cases it is considered that the disability is the same percentile figure as the impairment, and this is the way it should be - namely that looking at impairment versus disability versus handicap, a person may have an impairment, but that does
30 not necessarily mean that he will have a disability.

But a person cannot have a disability unless they

A. (cont'd.) also have a pre-existing impairment.

That is, in other words, not pre-existing the accident, but an identified impairment.

At the same time, a person may have a disability but does not have a handicap in excess of that disability, but there are other situations where an individual will have a handicap in excess of that disability.

A good example of that is a person who has a permanent impairment that is evaluated at ten percent, and in this particular instance it is evident that his ability to return to his employment and compete in the general work environment has been affected, and it is determined that it has been affected, as close as one can arrive at it, by a figure of ten percent.

However, that person does not return to employment, and the reason he doesn't return to employment is other factors, and the other factors may be that his basic education is such that he cannot go to alternate types of employment, or he cannot be retrained. Or it may be that he is reaching the age where it is extremely difficult for him to find new employment, or it may be that he has reached the age where he wants to withdraw himself from the labour market - he is coming up close to retirement time.

Or it may be problems that he has at home with his wife and family that are mitigating against his ability to return to his employment.

This is the handicap factor, and the handicap factor in a person who does not return to work can be as high as a hundred percent, because if he doesn't return to work, he is totally disabled - but due to a multitude of reasons.

Now, the Board deals with that, the claims services division, because when they identify a discrepancy between the

5 A. (cont'd.) disability and the handicap, then they apply a supplemental award to address themselves to that discrepancy, and I'm sure you are familiar with the supplementary awards.

10 And that's one of the main reasons that they are applied, is to recognize that indeed in certain instances...or in certain cases for certain intervals of time...that the handicap may be in excess of the disability.

15 Q. Well, not to belabour the point too much, and leaving aside for a moment the question of supplements, I'm still not exactly clear as to the actual permanent disability rating... that is, the pension forty-three, one...whether that can represent more than just the clinical rating, from your understanding.

20 A. From my understanding, if there was going to be a variation from the clinical impairment, then that would indicate to me that the claims adjudication people were of the opinion that the degree of disability was in excess of the impairment, and under those circumstances undoubtedly they would refer it back to the claims review branch, or directly back to the medical branch, and request a further evaluation.

25 No, to answer your question, by and large it's as it should be - namely, that the percentile of clinical impairment also, if a disability does exist, will represent up to that percentile of disability.

30 In other words, what I'm saying is that you may have a ten percent impairment, but no disability. You are able to compensate and you go back and you have no lost time from work, and it has no adverse effects upon your health, and therefore you have no disability.

But by and large, where there is a disability coupled with an impairment, that disability is the same percentage

A. (cont'd.) as the impairment, yes.

5 Q. Now, I just have a series of very brief questions which I would like to go through. First of all, you mentioned earlier the hospital and rehabilitation center, and I'm wondering whether or not there are many asbestos-related cases that are involved with the H and RC?

10 A. No, we do not admit cases to the hospital and rehabilitation center for treatment or assessment of asbestosis, cancers, heart conditions, these sorts of things, no. It is a rehabilitation center for trauma.

15 The reason for that is that we feel, the same as we do with people that have had spinal cord injuries - the paraplegics and quadraplegics - we feel that there are facilities that can manage these people just as well as or better than we could, and we don't want to duplicate good services, so that's why we utilize Lyndhurst Hospital, for instance, and other comparable institutions in the treatment of paraplegics and quadraplegics, and this is why we feel that the handling of chest disease problems can be just as readily done by local
20 physiotherapy facilities if breathing exercises are required, by evaluation in local pulmonary function laboratories, these sorts of things.

25 Q. Another quick question I have is concerning the file access policy, and Mr. McDonald, the last time he was here, provided us with copies.

I would just like to ask whether or not you are aware, since this policy has been in effect, how often the...well under two point three in the guidelines it indicates that..I'll just read it, it's quite brief:

30 "The worker or his duly authorized representative has full access to the claim file, except for medical information contained in a report which,

Q. (cont'd.) "in the opinion of the Board, would be harmful to the worker if disclosed".

5 I was wondering if you have any rough idea of how often, up until now, that particular section has been invoked?

10 A. Yes. In about the last figures that I had, and these are off the top of my head, except for the number of cases, the last figures I had from the registrar of appeals, there was around about three thousand cases where copies of documentation had been requested and given, relating to appeals situations, and there has been one instance where it has been the opinion of the committee that has been set up to look at this that a document in that one file of that one case was considered to be such that it should not be released to the patient.

15 Q. I don't suppose that was related to asbestos, was it?

A. No.

20 Q. Just to follow up for a moment on another earlier question, which was, I guess, just before the break we were discussing the idea of public input into guidelines, I think.

25 Actually, maybe before I ask that if you can very briefly outline, from your point of view, is there any substantive differences between policies, guidelines and directives, as far as the corporate board is concerned, as far as you are aware?

30 A. Yes, there are. The policies are definitive decisions that have been made by the corporate board on whatever matter they are addressing, and the directives are not necessarily.. in fact, the rule now is that they do not come from the corporate board, they might come from the vice-chairman of administration, but not from the corporate board...and the directives are administrative documents, by and large, which are to be used by the Board staff in carrying out their duties and in the utilization of the Act, and so forth and so on.

5 A. (cont'd.) The guidelines are, again, separate from that, because they are to be used in the assistance of the Board staff involved in the adjudication of certain groups of claims.

Q. Would all three of those areas, though, have to be approved by the corporate board, or for example you mentioned directives could emanate from, I believe you said the vice-chairman of administration...

10 A. Yes.

Q. ...so would that have to go through the corporate board first, or could it just be issued?

15 A. No, not necessarily. I might issue, for instance, an administrative directive to a certain group of my staff, and that is for their information and for their direction.

Q. I see.

DR. DUPRE: So only policies and guidelines would bear the stamp of the board?

THE WITNESS: That is correct.

20 There are some directives that will come from the board from time to time. In other words, the board has the power and the ability to issue a directive, just the same as the people that the delegate certain portions of authority to.

25 MR. McCOMBIE: Q. Okay. Well, having cleared that up, I would like to get back for just a moment to the question of public input, and in this case into guidelines, and you had a fairly long discussion about it this morning.

30 I am just wondering how you see...I mean, I look at the analogy of the Ministry of Labour's current hearings into various designated substances and toxic substances, and as I understand it there is a fairly open process there in dealing with the particular designated substances, and also the exposure criteria that they have issued.

5 Q. (cont'd.) I'm wondering if...you know, I don't want to take you too far beyond your area of expertise, but do you see that that would create the kind of problem that you were expressing this morning, of too much...or a perception that there is a political decision being made whereas a scientific one should be made?

10 A. Well, I think that one of the differences that I would identify is that the hearings that the Ministry of Labour have been holding have been to obtain input and opinions that are relating to their development of regulations, and regulations are not pure scientific documents, as you can appreciate.

15 Regulations have various components to them - legal components, social components, scientific components - so that I think that's the great difference that I see, really, between the two of them is that what they are dealing with are different from scientific guidelines.

20 Q. Well, I'm thinking in particular of the exposure criteria document that strikes me as being fairly specific in a scientific way, of particular numbers of exposure, and this is what the public has been asked to comment on - whether X parts per million of Y chemical is or is not a good TLV.

25 A. Well, again, I don't think that you can compare regulations outlining or detailing the recommended maximum levels of exposure to various substances and the compensation board guidelines, because once again while they may quote specific figures in the final regulations, nonetheless the fact remains that they are the most acceptable data that they have developed, and they are not pure scientific data, but they are predicated upon socioeconomic factors, upon political factors.
30 As you can appreciate, in many of the submissions it has been suggested that the TLV should be zero, and that's a reasonable

A. (cont'd.) approach to take.

Or if it cannot be zero, then the worker should be removed from exposure through engineering, through appropriate engineering developments.

So it is still, in my opinion, different from the guidelines which we use.

Q. Can I ask, again, just a brief question?

You have indicated that a lot of the...I guess the role of your department has been to research literature in particular areas, and also to, I guess, contract out, if I can use that expression, some research in particular areas.

I am wondering if the WCB itself has ever been involved in a particular research project, within its own organization?

A. Yes.

Q. It has?

A. Yes. Primarily in the field of trauma, we have done a considerable amount of inhouse research in back surgery, in identifying early back clinical factors that we feel may be of real importance in handling of cases.

One of our staff has done a research project in meniscus injuries to the knee and Dr. Chovil, when he was with us, did several inhouse studies as it relates to evaluating epidemiological methods and the best way of utilizing mortality statistics in epidemiological studies - these sorts of things.

Q. Have any of those studies involved industrial disease?

A. The ones that Dr. Chovil was working on involved primarily industrial diseases. He was not looking at the trauma type of case, no.

Q. Would these studies have been published, and if not are they available in some way for people that are interested?

5 A. The one study that he did on the incidence of cancer was published. The other one has not been published, and the manuscript has not been released by Dr. Chovil since he has left us.

Q. So this would be his own property rather than that of the Board?

A. Yes, that's right.

10 Q. In discussing with Mr. Laskin this morning the schedule three, my impression from your answer was that, whether it was explicitly or implicitly decided, certainly my understanding is that the best route to take was to take one of guidelines rather than either regulations or legislation, or setting something down in that fashion. Is that correct?

15 A. Yes, that's right. We felt that by utilizing guidelines, by developing guidelines, that that would give us the greatest latitude.

20 For instance, if we want to change a guideline, we do not have to change the Act, so that this gives us freedom there to move within the guidelines, and indeed this is what we have done for several guidelines is, we have revised them and it has not been necessary to have the Act amended in order to do this.

So we feel that the application of guidelines has worked out pretty well for us.

25 DR. DUPRE: Could I just ask you to clear up one point for me?

My understanding, if you want to change schedule three, is that what is required is not a legislative amendment, but simply a Cabinet order-in-council. Schedule three is in the regulations, is it not?

THE WITNESS: I really can't answer. I'm not certain.

30 MR. McCOMBIE: I believe that to be the case, too.

DR. DUPRE: Okay. It came out differently.

MR. McCOMBIE: Q. Well, appreciating that the Board is not bound by precedent, I am aware that you certainly are in touch with other jurisdictions.

I am just wondering whether you are aware of, and if so have any comment on, the bill that is currently before the House of Representatives in the U.S., on asbestos, in which there is an irrebuttable presumption right in the legislation, as far as mesothelioma goes and as far as asbestosis goes, and also a strong presumption as far as lung cancer goes.

This seems to be going in a completely different way than the WCB here is.

THE WITNESS: A. Well, yes, I am aware of these activities, but I must confess that I really don't know what the ultimate direction is going to be if they are passed into law. I don't really...I don't really understand how or under what circumstances, indeed, they may or may not be applied.

I think that what they are saying is that this is a first step in compensation legislation in the United States, that if a person does have a history of exposure and if he does develop a disease which has been identified with that particular substance, then that opens the door that indeed he does not have to go to the ultimate in order to at least address the fact that a claim can be set up and all the documentation can be reviewed.

Q. Okay, I have just one final question, Dr. McCracken, and while I realize that you are here in your capacity as executive director of medical services of the WCB, and therefore relating strictly to the compensation end of things, I was quite interested in a news story that appeared in the Globe and Mail on April 5th, 1980, in which you are quoted...and first of all I want to make sure that you were quoted correctly... concerning asbestos levels.

You are quoted as saying, quote:

5 Q. (cont'd.) "Anyone who says two is too high is guessing at something not based on numbers. It's very easy for people passing regulations to say point five is right, but they don't have to look at the economics". End quote.

First of all, I am wondering if that is a fair quotation or if you were misquoted.

10 A. Well, I have some recollection of that interview and it would be my opinion that if indeed I did say that, that it was not my full intention to do so, or that the information was changed in the news article.

15 What I did say was this, and this is my recollection and it's still my opinion, and that is, with the advent of the two fiber regulation, what I was attempting to convey to the reporter was that...and I believe I said the jury is still out, it's my recollection...and what I was saying was at that point in time no one really knew, nor did they have the figures or data to make the statement, that this was a sufficiently low level to prevent further development of asbestosis cases, or that it was an insufficient level and so further cases of asbestosis would evolve with people going into risk at that level.

20 That's what I was saying, and I quite agree with you that it really didn't come out the way that I intended it.

25 Q. I guess the one part in particular that concerns me is the suggestion 'they don't have to look at the economics', and I guess the question that arose in my mind when I read that is that you are a medical doctor and you are working for the Workmen's Compensation Board, and in both those capacities it strikes me as...I mean, that strikes me as yet again a third consideration that I feel, rightly or wrongly, shouldn't be involved in either medicine or administering the Workmen's Compensation Board from that side of things, and I'm just

30

Q. (cont'd.) curious as to what you meant by
'look at the economics'.

5 I mean, it seemed to be suggesting to me that you
were concerned with the financial situation of the companies.

A. Again, I would be of the opinion that there is
a certain amount of misinterpretation in what I was attempting
to convey to the reporter.

10 It's my recollection that what I was attempting to
convey to the reporter is not that I was concerned about the
economic impact, but what I was attempting to convey to the
reporter was that persons who are not involved in the administration
of workers' compensation but who are outside of that field, and
who express an opinion that yes, they can see no reason why all
15 cases of bronchogenic carcinoma that occur in asbestos workers
should not be allowed, that they are approaching it without having
to take into consideration any factor except their own perception
of the problem.

MR. McCOMBIE: Okay. Thank you very much, Dr.
McCracken.

20 DR. DUPRE: Mr. Starkman?

CROSS-EXAMINATION BY MR. STARKMAN

Q. Dr. McCracken, is section fifty-four of the Act
the only section dealing with rehabilitation?

25 A. I believe it is.

Q. I'm just wondering with respect to the special
programs that you described, for the Elliott Lake miners and
the special program at Johns-Manville, why was there a need to
set up these special programs? I guess specifically, why wasn't
the...why weren't the diseases and injuries at those various
30 places dealt with in the normal course?

A. Well, I...first of all, I shall attempt to

A. (cont'd.) answer that question, but it also overlaps into the claims interpretation of the Act.

5 But what we were dealing with here in the special rehabilitation program was different from general rehabilitation in that we were dealing with, in the instance of the miners, with miners that had radiation exposure, but they had no disease, they had no lung cancer, they had no claim.

10 Similarly, with the asbestos workers, we were dealing with a group of asbestos workers who had asbestosis and who had no allowable claim.

Section fifty-four is quite specific, really, that it applies or must be applied to those cases where there is an allowable claim.

15 In order to overcome...

Q. That was the Board's interpretation of fifty-four, that there must be an allowable claim before the Board can offer rehabilitation?

20 A. That is correct, and in order to get around that problem we used fifty-four, but we used it in the context that this was a special preventative program that might prevent the development of disease, and under the Act we do have the authority to be able to take those steps.

25 Q. So essentially, yes, I understood that was the Board's position as well, and I think what I'm asking is, you didn't get any special legislation or authorization from government to set up those programs?

A. Well, I didn't, but...

Q. Did the Board, though?

30 A. ...obviously the Board gave this careful consideration, and in their wisdom they felt that they would be able to take these steps without obtaining special legislation.

Q. So they decided, after considering it, that

5 Q. (cont'd.) fifty-four was broad enough to allow them to offer a rehabilitation program to those persons who had some levels of exposure but had no demonstrable disease?

A. That is correct.

10 Q. So I ask again, if that's the interpretation which they are able to put on fifty-four, why didn't...why would they need to set up a special program to do that, and restrict it?

15 I guess what I'm asking is, why would they restrict it to, let's say, Johns-Manville? Why wouldn't they say 'this program is available to asbestos workers'?

A. As a matter of fact, the program was available to asbestos workers.

20 Q. All right. But it wasn't just to Johns-Manville?

A. No, no.

25 Q. All asbestos workers were eligible to participate in the program?

30 A. That is correct. And again, I must say that the reason that it was identified as a special program both for the uranium miners and then for the asbestos workers, was due to the fact that we were dealing with cases where there was no allowable claim before the Board, and therefore the Board considered that in order for them to utilize section fifty-four, it had to be utilized in a very specific manner by the setting up of a special program concept.

35 Q. Perhaps I'll take it up again with Mr. Pearce, but I recall him saying that with respect to the...I don't have the numbers in front of me...but with respect to the thirty-two people who were eligible to participate in the program, some of them had diagnosed asbestosis?

40 A. Yes, that's right.

Q. So wouldn't those people have been eligible under fifty-four?

A. Yes, they would have. No question about it.

Q. So some of the people would have been eligible?

A. Any of the cases of asbestosis that had a claim allowed and that had a permanent disability award, under the Act they are in a position where they can avail themselves of vocational rehabilitation services which would include the services that were given in the special program.

However, they were included in the special program so that we wouldn't have duplication.

In other words, we didn't want one group of workers that had allowed claims with pensions being dealt outside of the special program, and the rest being dealt within the special program. We felt that for the program per se it was much better to include all the workers in that one program.

Q. So all asbestos workers were included in the special program?

A. Yes, that's correct.

Q. Now, we understood or I understand that in order to be eligible for the program you must be working or have been working on May 13th, 1976, in a risk area?

A. Not to my knowledge. The criteria...one of the criteria is that to be eligible to enter into the program, it must be identified that you are working at risk, and I don't identify any particular date.

In other words, as the workers were interviewed, at the time of interview if they were working in an area which was identified as being at risk, irrespective of the date, then they could indicate their willingness to enter the program.

Q. So let's deal with that proposition first, and I understand there were two areas that were considered to be risk areas at the Johns-Manville plant in West Hill.

A. I can't vouch for that. I don't know. I don't

A. (cont'd.) have those details.

Q. All right. The decision to make the special program available to only those who were working in risk areas, when was that decision made?

A. Well, that was part of the special program document itself.

Q. You mean it was made right at the beginning?

A. Yes.

Q. Before the interviews were done?

A. That's correct.

In other words, part of the requirements were that a person would be eligible to enter the special program if he was at risk. That was part of the criteria.

Q. Why was that made part of the criteria?

A. Well, because, this was a preventive program and in the first place nobody...no medical expert could tell us whether or not this was the correct thing to do. We had to make a real presumption that even if there was only one case down the line somewhere, where someday we may be able to say because of the fact we took that one case out of risk we prevented him from developing asbestosis, then it's a success as far as I'm concerned.

But at the time that we were into the program, at that stage of the game nobody could tell us that this was the right or wrong thing to do, or if it was even worthwhile. So that the name of the game and the reason for the special program was to remove people who still were in a situation of ongoing risk of developing asbestosis.

Q. On the theory that asbestos would remain in certain parts of any given manufacturing establishment?

A. That's right. In other words...

Q. There were risk areas and nonrisk areas?

5 A. ...in other words, a person who continued to breathe asbestos particles, we wanted that person, if he was agreeable and if he had asbestos fiber dust effects on the clinical evaluation, or if he had asbestosis, we wanted that person to be given the option to say yes, I would like to go on the special program and come out of risk in the hopes that I will either not develop asbestosis, or in the hopes that my asbestosis will not get any worse.

10 You couldn't give them any guarantees with either.

Q. Of course. But the feeling was that if someone had asbestos fiber dust effects and was transferred over to work in the fiber glass division part of Johns-Manville, that they were out of risk of asbestosis?

15 A. I believe that that is...

Q. That was the decision that was made.

Now, what about other asbestos manufacturers who were eligible for the program? What arrangements were made there?

20 A. What we did was, we developed a list of various companies that utilized asbestos, and contact was made with a number of these companies and requests were made if they could identify any cases that they might have concern about, over and above that we reviewed our claim cases to determine what the sources were. In other words, did we have any cases of asbestosis coming from sources other than Johns-Manville, for instance. This was a claims activity, and I really can't answer what you are asking...

25 Q. Mr. Pearce would be the one to ask?

A. That's correct. Mr. Pearce would be the one, or someone from the claims services division.

30 Q. Now, I guess...are people...do people continue to be eligible to enter the program?

A. Yes.

Q. As long as they meet the requirements of having some exposure or some evidence of asbestos fiber dust effects...

A. That's right, if they have asbestos fiber dust effects or if they have asbestosis, and if they are at risk.

Q. The other details, of course, we would ask Mr. Pearce, because he has been intimately involved with this?

A. Yes, that's correct.

Q. You were talking earlier about guidelines as opposed to putting certain diseases in the regulations, schedule three. I guess you are aware of section one twenty-two, nine, the presumption section?

A. Yes.

Q. So as I understand it then, if asbestosis...or if asbestosis specifically, or pneumoconiosis, had a column two, in schedule three, then someone that had this illness would be deemed... it would have been deemed to have been caused from his employment? Is that correct?

A. If that conforms with the intent of schedule three, yes, and I believe it does.

Q. Deemed to have...unless the contrary is proved?

A. Yes.

Q. In other words, the burden would have drastically shifted from the claimant to...I don't know who else...to the employer, is the only other party, I guess, to prove that it was not caused from employment?

A. No, I don't visualize that the burden would shift, because that has no bearing upon arriving at a diagnosis of asbestosis. Under the present situation that prevails, where a claim is submitted, a letter from the worker or his representative or whatever the source might be, then the Board immediately has a responsibility to carry out the necessary investigation to determine if that individual has been exposed to asbestos.

A. (cont'd.) The same would prevail, it's my understanding, if it were under schedule three.

Then, once that has occurred, then the Board still has a responsibility through the chest advisory committee to either make a diagnosis or not make a diagnosis of asbestosis, so that the diagnosis is the responsibility of the Board and it is not the responsibility of the worker.

Q. All right. I would like to run through how the diagnosis is made, because I am still somewhat confused.

As I understand it, the question of entitlement on an asbestosis claim rests with the person who is adjudicating the claim - the adjudicator?

A. That is correct.

Q. They are making the decision?

A. That's right.

Q. Now, as I also understand it, we've been told again and again and I think you've confirmed this, that there are very few people in this province, very few experts, who are capable of making this diagnosis because it's a very specialized field and it's a difficult diagnosis to make. Would I be correct in that?

A. Yes, that's right. There are a few people that are considered to be qualified experts.

Q. But the people.....at least in the Board's opinion...the people who sit on the advisory committee are such experts?

A. Yes, that is correct.

Q. So we have a group of experts, and can you think of others, any others who would be qualified to make that diagnosis?

A. Oh, yes. There are a few radiologists throughout the province that have had sufficient exposure that I am of the

5 A. (cont'd.) opinion that they are quite competent to make the diagnosis on radiological examination, but then again they are not in a position to then enhance, in a questionable case, to enhance that data by pulmonary function studies.

In other words, it's most unusual for a radiologist to also be in a position that he can evaluate pulmonary function studies. He is the expert in his field, but not in the other.

10 So this is the problem.

Q. So basically the opinion that you get from the advisory committee on whether or not someone has...is asbestotic, is one of the best opinions you are going to get in this province, according to you?

15 A. That's right.

Q. So it's unlikely that anybody is going to be able to get evidence to challenge the opinion of the advisory committee, given their statute and their experience?

20 A. Well, I don't think it's a matter of challenging their opinion. What happens not infrequently is that in the surveillance program a report will be sent out, and at this stage of the game there is not even a claim with the Board and we don't even know that that particular person exists, but he is part of the surveillance program, and a report will be sent out by the Ministry of Labour, formerly Ministry of Health, that for instance there is evidence of a plaque being developed in the pleura.

25 Q. You receive those reports from Grosvenor Street?

30 A. No, we do not receive them. These reports are sent out to the man's attending physician, and not infrequently the attending physician will look at the report, without ever having seen the x-ray, and will come to the conclusion that this can only mean one thing, and that is that his patient has asbstosis.

What the chest advisory committee attempts to do is,

5 A. (cont'd.) when the case comes to their attention, they attempt to resolve this difference of opinion - not challenge the diagnosis of the family physician, but to indicate as a result of their studies that while the individual is showing signs of a plaque developing, that he does not clinically have asbestosis.

10 Q. But when someone makes a claim for asbestosis, as I understand it, it goes to Dr. Stewart or Dr. Dyer, who refer to the advisory committee, who then communicate a decision back to one of the doctors?

A. That's correct. That's separate from the surveillance program.

15 Q. Yes, I understand that. I'm trying to stick with the adjudication.

They communicate it back, and that's their opinion. And then Drs. Stewart and Dyer pass that opinion on, essentially...

A. Yes.

20 Q. ...to the adjudicators? They really don't change that opinion at all?

A. No, that's right.

Q. They just pass it along?

A. That's right. Very rarely, very rare.

25 Q. Now here you have the adjudicator who is supposed to be sitting on the question of entitlement. Now, we know there is only very few doctors who are capable of making this decision. The best doctors in the province have not adjudicated, but have given their opinion.

30 What is the adjudicator supposed to do when he is looking at the question of entitlement, and what room is there left for the adjudicator, realistically speaking, to do anything other than confirm what the advisory committee has said?

A. Well, there are quite a number of things that the adjudicator has the responsibility to do, and I'm sure that

A. (cont'd.) Mr. McDonald could address that much better than I.

But for one thing, they have to take a look at the history of exposure once again, to ensure that indeed the history of exposure does exist.

They have to take a look and make sure that it complies with the two year limit in the Act, for another thing.

Q. Assume we've gotten over those, we are at the question of the diagnosis of impairment. If we are at that stage, what can the adjudicator do other than confirm the decision, confirm what the advisory committee has said?

A. Well, the alternative that the claims adjudicator has is that if he is uncomfortable with any part of the claim, then it's within his prerogative to refer the claim back to...if it's a medical concern that he has...back to Dr. Dyer or Dr. Stewart. If it's a nonmedical matter, then indeed the matter may be referred - if it's a matter of rejection - it will be referred to the claims review branch.

So they do have a responsibility that they must exercise, and they must ensure that the claim conforms and that the letter of the Act is carried out.

Q. Don't you think that the benefit-of-the-doubt principle should apply not only to the question of adjudication, but in the types of situations we are dealing with here, with asbestos claims, where I would suggest the adjudicator, because of their lack of medical knowledge and the specific type of knowledge, is really obliged to accept the advisory committee's finding, isn't it...shouldn't the benefit-of-doubt principle, wasn't it intended to apply to the question of the medical finding?

In other words, when there is a question of whether or not someone is asbsetotic, they are to be given the benefit of the doubt in terms of making that sort of determination?

5 Q. (cont'd.) I mean, as I understand it, and I am a layman here, there is a huge grey area we are dealing with here, not like broken fingers and other traumas. There is a very grey area, and wasn't this designed to allow the benefit of the doubt as to whether someone has an impairment, give them the benefit of the doubt when there is a dispute on the issue, potential dispute?

10 A. Well, now, you are mentioning impairment, and that implies that we are in a situation where diagnosis has been made and the diagnosis is asbestosis, in which case the claim is an allowed claim.

15 Q. All right. I'll back up then. The question is diagnosis. Shouldn't they get the benefit of the doubt at the diagnostic stage?

A. Well, I would submit that they do get the benefit of scientific evaluation - not doubt - evaluation.

20 In other words, I do not see how benefit of doubt can apply to arriving at a clinical diagnosis. Either you have the disease or you do not have the disease, and it's based upon the preponderance of clinical data.

25 Q. We heard from Dr. Vingilis that there are five members sitting on the advisory board, let's say, on a given day. There may be disagreement between them as to whether or not someone is an asbestotic, and they talk amongst themselves and... I'm unclear whether they arrive at a consensus or they just agree to disagree...but only one report goes on back to the board, where in fact there may have been disagreement.

30 Don't you think that if there is disagreement in the advisory committee, then there can be disagreement on this question, that that is a doubt, and that that doubt should be communicated to the board and to the claimant that of the doctors considering it, some felt that it was asbestotic, some weren't

Q. (cont'd.) sure, some may have felt otherwise?

5 A. Well, so far as communicating that to the claims adjudication staff, I don't think that that would be of any assistance to them at all, because the responsibility to make the diagnosis rests with the chest advisory committee per se, and in a situation where you have three saying yes and two saying no, under that situation the majority decision would undoubtedly prevail and it would be finally joint consensus that the person
10 does have asbestosis.

Q. Yes, but let me just...I don't want to go...I just want to go at it one more time.

The first sentence of the directive on benefit of doubt says, "the benefit-of-the-doubt principle is applied to
15 all levels of decision making at the Board".

Now, the adjudicator is the one who is going to make the decision whether someone has the disease or not, is that right?

A. That's right.

Q. I mean, the ultimate decision rests with them, so when they are making the decision aren't they entitled to have the benefit of...they are entitled to the benefit of the advisory
20 committee's report, but shouldn't they also be apprised that there may have been conflicting opinions on the advisory committee?

Because then if there are conflicting opinions, the adjudicator may sit there and say well, the experts have conflicting opinions, maybe there is a doubt and I should give the benefit of
25 the doubt to the claimant.

A. Well, again, really I think that the only thing that can be done is to give the best available diagnosis to the claims adjudication staff.

In the instance of where there is a divided opinion and the decision is that the individual does not have asbestosis, then the situation that prevails there is that that person is
30

5 A. (cont'd.) under the surveillance program and that person also is marked down for reviews, and as Professor Barth points out, that it's quite common in the course of review for the chest advisory committee to change their opinion from a rejected case where there is not asbestosis to a case where indeed there is asbestosis, and this is due to progression of the disease and more definitive clinical information being developed.

10 This is the way that, in my opinion, that it should be applied.

Q. I agree. When there is new evidence, everyone is always entitled to reconsider.

A. That's right.

15 Q. But it seems to me what I'm hearing is, you make it sound as if medical science is like physics in that it can easily be...you know, it either is or it isn't. Whereas wouldn't it be fair to say that in questions of diagnosis of this sort there is a large grey area? A large area of uncertainty in which highly-specialized and trained people often do disagree?

20 A. I wouldn't classify it as being a large area. I would say that there is an area where indeed it is difficult to determine whether or not the individual has a medical diagnosis of asbestosis, or whether the diagnosis is asbestos fiber dust effects.

25 I don't think that it's a large area.

In other words, from my knowledge of the activities of the chest advisory committee, the usual case is a unanimous opinion that asbestosis does not exist, or a unanimous decision that asbestosis does exist.

30 Now, there is the occasional case where there will be a difference of opinion, but the purpose of the chest advisory

5 A. (cont'd.) committee is not to foist that onto a claims adjudicator that he must make a determination as to whether or not the individual has asbestosis, because that's in effect what you are suggesting that the claims adjudicator is going to have to do.

10 We feel that that is...he is not trained to do that, as you indicate, that he is not a highly-qualified specialist, and therefore if our chest advisory committee group cannot arrive at that diagnosis, we really feel it's unfair to expect the claims adjudicator to do so.

15 So that I really think that it's inappropriate for the claims adjudicator to apply benefit of doubt to a clinical diagnosis.

20 Q. I guess what I'm really suggesting is that the benefit of the doubt should apply in making the diagnosis. I'm not...I agree that the claims adjudicator is in a very difficult position, but we also heard the advisory committee really has no communication with the board as to their policy, so I assume they wouldn't know about the reasonable doubt policy?

25 A. Oh, yes, they do.

Q. How would they know about that policy?

30 A. Well, during the course of our meetings and discussions, and Dr. Stewart meeting with them, they are...I would say the majority, if not all of the members, of the chest advisory committee are familiar with benefit of doubt.

35 But having said that, what we expect of them is not to express benefit of doubt. We expect of them to express an opinion relative to a diagnosis, and also relative to probability.

40 Q. You see we are sort of in an impossible bind here. If the benefit-of-the-doubt principle is supposed to apply, is to apply in terms of making a diagnosis, and the advisory committee is not supposed to express opinions on doubt but only on

5 Q. (cont'd.) clinical diagnosis, and the adjudicator is not in a position to apply the principle with respect to diagnosis, then we are in a very difficult position because the benefit-of-the-doubt principle doesn't get applied, it gets lost.

A. No, I don't think that it gets lost.

Q. Why? Why doesn't it get lost?

10 A. Well, because the claims adjudicator is in a position to apply the policy of benefit of doubt in those situations where the evidence is equally weighted, and where the evidence is not equally weighted, well then there is no requirement to apply benefit of doubt.

15 Q. You mean when the evidence is equally weighted on the question of entitlement? I mean, excuse me, on the question of diagnosis?

A. Yes.

20 Q. Now, wouldn't it be fair, this is where I started and probably where I'll end, but wouldn't it be fair to say that when you have a small group of people who are very... a few people who can make this sort of diagnosis, and they are concentrated on the advisory committee, and the advisory committee is in constant...has a working relationship with the Board, that it's going to be very difficult for a claimant, your average claimant, to get together the type of evidence which is going to lead the adjudicator to do this sort of weighing of the evidence that you are suggesting, because all the expertise, most of the expertise, is going to rest with the advisory committee's decision?

25 A. Well, of course, my response to that once again is that to my knowledge the claims adjudication branch does not require the worker to get together the evidence to support his claim.

30 As a matter of fact, that is - as I've said - the

A. (cont'd.) responsibility of the claims adjudication branch, and they must do that.

5 I would suggest in the hypothetical case that we have been talking about, that in a situation where there was a very significant of opinion, but that the majority of the chest advisory committee felt that the person at that point in time on all the evidence did not have asbestosis, that what they would do is they would make a recommendation that that case did not have asbestosis at the time of the current review, but that the case should be reviewed in six months.

10 Q. Yes, I understand that.

15 Well, moving onto appeals, you were asked about the appeals and the suggestion was that the advisory committee would review it, and if there is new evidence they might change their opinion.

20 I entirely agree with that. I want to stick with the case where the advisory committee sends in an opinion that a person does not have a disease, the matter is appealed, and then it could go back to the advisory committee at that point?

A. Yes.

25 Q. All right.

Now, doesn't it seem to you...it seems to me...that in that case the advisory committee is unlikely to change its mind? As a matter of fact, probably would bend over backwards not to change its mind? They made a diagnosis, and if there is no new evidence aren't they very likely to stick by their diagnosis?

A. Yes.

Q. And the same all the way up through the process? All the way to the appeal board level? And to the corporate board?

30 A. Yes. If you say...in the appeal environment, the nature of an appeal is that the appeal is to be heard, hopefully based upon new evidence that will be submitted, and/or review of

A. (cont'd.) current evidence.

5 Q. That's for reconsideration of a decision. A person has a right to appeal the decision of the adjudicator whether or not there is any new evidence?

A. That's right.

Q. On the basis that an error was made?

10 A. That's right. That's as I say - and/or review of the current evidence.

Q. Yes.

15 A. Because that is in effect what happens. In the hypothetical case that you are discussing, you are saying in effect that the worker feels that he does have asbestosis, he has been told no, you do not have asbestosis, therefore you do not have a claim with the Board. He appeals that decision and no new medical evidence is forthcoming.

20 Then in a situation like that, what will occur is that the content of the file may be re-examined by Dr. Dyer or Dr. Stewart, from a medical standpoint, and they will come to a conclusion relative to the diagnosis.

25 Q. How are Dr. Dyer or Dr. Stewart, in the re-examination of a file, going to overturn the opinion of the advisory committee?

30 A. Just the same way as they may overturn the opinion that is in any other file from an orthopedic surgeon or from a neurosurgeon, is that on examining the file if they find that some factor has been overlooked, something is in that file that has not been taken into consideration from a medical standpoint, then indeed this is the...could be a factor in reversing the decision.

Q. You mean the advisory committee missed something?

A. Correct. That's right.

Q. Why didn't they do that sort of review at the

Q. (cont'd.) first stage, at the adjudication level?

A. I don't follow you there.

Q. Well, why, when the...why wouldn't that review that you are suggesting might go on, why didn't that happen at the adjudication of the claim in the first instance?

A. Well, it will in the situation where a claim is denied. It must then be reviewed by the claims review branch.

Q. Exactly. So it has been done when you get to the first level of appeal?

A. Right.

Q. All right. So it's already been done when the claim is denied, and a claimant goes to appeal and there is no new evidence in the sense that the condition hasn't worsened, demonstrably worsened. I suggest the claimant can't possibly succeed.

A. In the situation like that, well then in all probability that claim will be referred back to the chest advisory committee, who will then obtain new x-rays, possibly some further pulmonary function studies, and will re-evaluate all the evidence.

Q. But they are just going over the same evidence they had before?

A. No, no. I said that they will obtain...they may obtain new x-rays, they may obtain further pulmonary function studies, and they will in all probability re-examine the patient for clinical signs - did he have no rhonchi in his chest when he was examined the time before, and they bring him back in and examine him and he now has rhonchi.

Q. What you are suggesting to me is that if someone appeals their claim, it would go back to the advisory committee and they will look more carefully, they will do a more

Q. (cont'd.) thorough job than they did the first time?

5 A. No, no, no. They will not do a more thorough job. What they will do is they will see whether or not any further investigation would be of any assistance to them in making a determination, and if they decide yes, it has now been four months since the last chest x-ray and this file is now back before us and this case is before us, we think it would be worthwhile, with 10 that passage of time, to get a new chest x-ray, then this is quite justified and is the correct clinical course to take.

Q. I understand what you are saying, but I think what troubles me about that procedure is it's almost as if the... that's not really how an appeal process is supposed to work.

15 I mean, granted there are long passages of time in every process, but you are supposed to be appealing the initial decision, not letting time pass so people can reconsider it as if it was a first-level decision.

20 A. Well, it's not...we don't allow the time to pass any more than we can help. What I'm saying is, that with the maturation of a claim that very often the time indeed has passed, so therefore when it's looked at, very often in certain cases it will be determined that further investigation well might be indicated.

25 Q. So by the time it comes up for appeal, inevitably some time has passed which therefore would justify a further investigation by the advisory committee?

A. May. May justify.

Q. Oh, it may? All right.

30 But if there is no further investigation, then the claimant really can't succeed on appeal, because the advisory committee's documents are just there as they were at the first level?

A. Unless there is something new that they have overlooked, something that they have overlooked.

Q. Okay.

Now, the guidelines...

MR. EDWARDS: I don't mean to interrupt, Mr. Chairman, but I am conscious of Mr. McDonald's time commitment, and I'm wondering if it mightn't be convenient to interrupt here to get Mr. McDonald on the stand.

DR. DUPRE: Well, I think one thing...we can be in Dr. McCracken's hands.

Do you have a fair number of additional questions?

MR. STARKMAN: Well, I had.

DR. DUPRE: Okay.

MR. STARKMAN: I could probably finish in about another five to ten minutes.

DR. DUPRE: Perhaps...let me ask Dr. McCracken... if you could bear with a long coffee break, until about four-ten, because I understand that is when Mr. McDonald has to go, I could turn Mr. McDonald over to Mr. McCombie, who is the sole representative here who hasn't had a chance to pose his questions yet.

Would you be agreeable to coming back at four-ten?

THE WITNESS: Sure, that's fine.

MR. STARKMAN: If I could take five minutes and finish, I think that would be the best thing to do, because I don't know if Mr. McCombie is going to finish anyway, before four-ten.

DR. DUPRE: One thing I don't want to do is to ask Mr. McDonald to come back here for a fourth time. So do you want to give Mr. Starkman five minutes now, and we'll get through with Mr. McDonald by four-ten, come hell or high water?

Okay. Go ahead.

5 MR. STARKMAN: Q. On these guidelines, you said one of the purposes of the guidelines was to...I believe one of the purposes was to publicize the Board's position and make known the Board's position on this, on these types of claims?

10 THE WITNESS: A. No, I don't believe I said that. I said that the guidelines were public documents and anyone having interest in them, that we were able to identify, as we developed them, we distributed them to those parties and then anyone making a request would receive them.

But that was not one of the purposes of the guidelines.

Q. And it was also...but it was to provide uniformity to decision?

15 A. That is correct.

Q. Would you agree that another way to achieve uniformity in the decision-making process would be for the Board to publish its decisions?

20 A. No, I don't think so. Because by publishing decisions, immediately such a decision tends to act as a precedent, and I'm not convinced that an individual decision should be used as a precedent to set the pattern for all future decisions, because that first decision could well be in error, and if you set it as a precedent, well then you obviously are into problems in correcting...

25 Q. It's right in the Act that you are not bound by precedent, so you wouldn't have to worry about that. But it would be a way, you would agree with me, it would be a way of achieving some sort of uniformity in the decision-making process by notifying at least other...notifying everyone involved, people working at the Board and others, as to what is happening in particular areas, particular claims?

30 A. Well, Board personnel are aware of how the

5 A. (cont'd.) guidelines are used, so I don't think that would be of any particular assistance to Board personnel.

The individuals involved in a specific claim are advised as to the outcome of that claim, so that I believe they are adequately informed, and certainly their representatives are, insofar as I'm aware, so that again I really don't see what role would be served by publishing decisions.

10 Q. Now, in the guidelines...

A. I know that it is done in British Columbia.

15 Q. Let's take the asbestos...the lung cancer guideline, where it says there must be a clear and adequate history of at least ten years occupational exposure to asbestos, and that determination is going to be looked into by the adjudicator?

A. Yes, that is correct.

20 Q. Now, let's take the case of a nonfixed site worker, a construction worker or demolition worker, how is that determination made as to whether they have sufficient length of exposure to meet the guideline?

A. Well, again, I really think that you are addressing the wrong person when you ask the question to me, but I will do the best I can.

25 Q. Who should that question be addressed to?

A. That should be addressed to either the executive director of the claims services division or to one of his representatives.

Q. Well, he's here. Why don't we leave the question and we'll ask it to him if he is better qualified to answer it.

30 MR. STARKMAN: Well, those are my questions. I'll leave it at that.

DR. DUPRE: Just one point, Dr. McCracken, and I

5 DR. DUPRE: (cont'd.) listened very closely to your dialogue with Mr. Starkman, also with Mr. McCombie, about the manner in which the benefit-of-doubt policy applies.

10 As you point out, it's more an administrative legal tool than a medical tool. It gives to adjudicators along the appeal ladder, as I take it, some assistance in what kind of evidence to accord greater weight to - that of a specialist as opposed to a nonspecialist, so on and so forth, and I can appreciate the benefit-of-the-doubt policy is useful, and doubtless is applied in questions that involve the cause of death of an asbestotic in the lung cancer cases, the GI cancer cases and so on.

15 I want to worry about Mr. Starkman's concern that life is a little bit different in the realm of asbestosis, where basically, as I take it, what is coming forward - at least from the ACOCD - is one collective consensus that may mask some disagreement.

20 One point that you have made, that again I want to think about, but there is doubtless something there, is of course that in the asbestosis case, to the extent that the disease is progressive, of course the disease itself, so to speak, permits the ACOCD to readjust the situation.

25 Now, let me ask you this - I suppose there is another point that I might take into account when I'm going to do all my worrying about this, and it runs something like this: In the asbestosis cases, of course, there may well be other medical opinions, your testimony makes this clear - from family physicians elsewhere, corporate physicians, as to whether or not the individual has asbestosis.

30 What you are doing through the ACOCD, I guess could be described in terms of your benefit-of-the-doubt policy, as securing a collective specialists opinion. Would that be right?

THE WITNESS: Yes.

5 DR. DUPRE: And at this juncture, of course, one has to ask oneself the question as to whether there may be grounds for, within the framework of the benefit-of-the-doubt policy, treating a collective specialits' opinion in the same way as one might treat a single specialit's opinion.

10 THE WITNESS: Well, I can only refer to jurisdictions such as British Columbia, that do indeed use outside medical review boards, and I believe that they are three-members boards, and I'm sure that from time to time there is disagreement among the three physicians. But what they do, according to my understanding, is that they debate the issues which are separating them until they come to a resolution of opinion, and there is only one opinion that is submitted to the Board.

15 DR. DUPRE: Is it your view that the proposed medical review panels, in the White Paper, may help us with some of these problems that we have been talking about?

20 THE WITNESS: They may. I think that they would have to be very carefully designed, and we would certainly have to obtain tremendous degrees of ongoing co-operation from the medical profession to make them work for us.

25 DR. DUPRE: Well, Dr. McCracken, may I thank you most warmly indeed for having been with us today. You have been very helpful. Thank you very much.

THE WITNESS: You are welcome.

---the witness retired

DR. DUPRE: Now, like ships that pass in the night, I'll call your executive director to replace you.

30 MR. JOHN McDONALD, PREVIOUSLY SWORN, RESUMES THE WITNESS STAND

CROSS-EXAMINATION BY MR. McCOMBIE

5 DR. DUPRE: Thank you, indeed, for returning, Mr. McDonald. This gives Mr. McCombie a chance to have his cross-examination.

Without further ado, may I call on you, Mr. McCombie?

10 MR. MCCOMBIE: Thank you. I hope this long build-up is justified.

MR. MCCOMBIE: Q. I apologize for the delay, Mr. McDonald, and I'll try and be as brief as possible.

I understand you have to leave at four-ten?

THE WITNESS: A. Yes, sir.

15 Q. Well, maybe we can both try and be brief.

First of all, to go over some of the things that were said the last time you were here, there was two statements you made at different times during the day, and I'm not sure whether I misinterpreted this or not, but I want to make sure I have it clear, and that is whether or not a claims adjudicator can or cannot make a negative decision.

20 A. On his own?

Q. On his own.

A. No, he has to...

Q. Without the claims review branch.

25 A. No, he has to refer that to the claims review branch.

Q. So in other words, the claims review branch is the lowest level of decision making where a negative decision would come from?

A. That's correct.

30 Q. You also mention that someone was preparing an analysis of both Barth's report and the critiques of Barth's report.

5 A. (cont'd.) She also spent some number of months out at our hospital and rehabilitation center, where she was involved in the actual practice of rehabilitation medicine and carried a case load of injured workers who were out there undergoing assessment and treatment, and again the senior staff out there supervised her activities until they were satisfied that she was able to assume a full case load.

10 Then when she finished that basic or initial training, then she returned to the area of industrial diseases and currently she is still being exposed to the expertise that has been developed by the other industrial disease consultant who has been with the Board for many years.

15 So it's a composite type of training, and over and above that it's my policy that members of my medical staff shall attend appropriate medical seminars, meetings, presentations, post-graduate courses that are apropos to the type of work that they are doing, and Dr....both Dr. Dyer and Dr. Stewart have indeed been attending such seminars and courses.

20 Q. I would assume this would be the case for all medical staff coming on board at the present Board?

A. That's correct.

25 Q. Another question that Mr. Laskin asked you this morning, and I would just like a very brief followup on this, he was asking you whether or not you saw any conflict between those that are setting the guidelines being in many cases those that are involved in the adjudication or recommendations on adjudication for cases, and you indicated that as far as you were concerned it wasn't a problem - in fact in some ways it was of benefit.

30 I'm just wondering if you see any conflict at all when these kind of cases go through the appeal system and we often see the same people making recommendations all the way up -

5 Q. (cont'd.) that is that one doctor gives a recommendation to the appeals adjudicator, that decision is then appealed to an appeals adjudicator who sends it back to the same doctor, and so forth, which is our understanding of what will often happen in an asbestos case, and I'm wondering if you see any conflict at all in that, or any perception of conflict.

10 A. Well, I wouldn't perceive that as a conflict, but I would perceive it as the same individual grappling with the same problems and trying to determine whether or not he should come to the same conclusions from a medical standpoint.

15 To overcome that, it's our policy that for instance if Dr. Dyer has been involved in a given claim and it gets into an appeal situation, Dr. Stewart is a person that the file is referred to, and vice versa.

20 If it goes beyond that, then not infrequently this is where Dr. Gray, who is also acting as a part-time consultant for the Board, will then become involved and it will be his responsibility to introduce his opinion and of course this is a separate function that Dr. Gray has from the chest advisory committee, in that...and it's primarily with the cancer claims where they don't come before the chest advisory committee in any event...and he acts as another consultant.

25 Beyond that, then our other course or avenue is indeed to obtain the opinion of another independent, outside consultant, which either Dr. Dyer or Dr. Stewart can use as a base for new information, new opinions, new evidence.

30 Q. Can I just make sure I have this straight? Did you say that if, for example, Dr. Dyer were involved in the initial adjudication and there were an appeal on that particular claim, that it would automatically go to Dr. Stewart?

A. Not automatically, but invariably this is the

5 Q. (cont'd.) "Anyone who says two is too high is guessing at something not based on numbers. It's very easy for people passing regulations to say point five is right, but they don't have to look at the economics". End quote.

First of all, I am wondering if that is a fair quotation or if you were misquoted.

10 A. Well, I have some recollection of that interview and it would be my opinion that if indeed I did say that, that it was not my full intention to do so, or that the information was changed in the news article.

15 What I did say was this, and this is my recollection and it's still my opinion, and that is, with the advent of the two fiber regulation, what I was attempting to convey to the reporter was that...and I believe I said the jury is still out, it's my recollection...and what I was saying was at that point in time no one really knew, nor did they have the figures or data to make the statement, that this was a sufficiently low level to prevent further development of asbestosis cases, or that it was an insufficient level and so further cases of asbestosis would evolve with people going into risk at that level.

20 That's what I was saying, and I quite agree with you that it really didn't come out the way that I intended it.

25 Q. I guess the one part in particular that concerns me is the suggestion 'they don't have to look at the economics', and I guess the question that arose in my mind when I read that is that you are a medical doctor and you are working for the Workmen's Compensation Board, and in both those capacities it strikes me as...I mean, that strikes me as yet again a third consideration that I feel, rightly or wrongly, shouldn't be involved in either medicine or administering the Workmen's Compensation Board from that side of things, and I'm just

30

A. That's correct.

5 Q. I'm just wondering if you could tell us who is preparing it and if you have any idea when it would be ready?

A. It is being prepared at the Board. I'm not sure exactly who is preparing it, and I don't know when it will be available, Mr. McCombie. I spoke...

10 Q. Do you know what department would be responsible for something like that?

A. The office of the secretary would prepare the brief.

Q. So that would be Mr. Joma's office?

A. Mr. Joma, that's correct.

15 Q. I believe you also gave some indication of training, as far as claims adjudicators went, and I guess a question that I would have is whether or not, within the training system for an adjudicator that is coming on to the ID and D section whether there is any medical or paramedical training of any sort, as part of that training process?

20 A. They are exposed to some of the medical papers that have been prepared in the past, as a part of their training program.

Any specific lectures, per se, I don't believe we have had any in recent times.

25 Q. So it wouldn't be part of the training process itself to attempt to familiarize them with the various...

A. Can I just clarify that point?

Ray, are there any medical lectures involved at the present time, with the training program?

MR. RANTA: There was one lecture that has been held over a half day, but it's basically training on the job.

30 MR. McCOMBIE: Q. Just a few questions on your testimony concerning appeals. I appreciate that there are others

Q. (cont'd.) that are more expert in this field, but if you could just share your knowledge with us.

5 You indicated that there was a manager of appeals adjudicators?

A. Yes, sir.

Q. And part of their function would be to assign adjudicators to appeals?

A. Yes, sir.

10 Q. I am just wondering whether or not there is any method in doing that or whether it is strictly by coincidence?

A. No. If they set up a trip to Sudbury, any cases that would be assigned to Sudbury, the adjudicator who was next in turn to go to Sudbury would be assigned all of the cases from that particular area.

15 There is no designation by particular types of disability, if that's what you are...

Q. Yes, I was wondering - so there wouldn't be particular adjudicators that would be considered...

A. No, sir.

20 Q. ...experts in say industrial...

A. No, they would deal with any case that came before them.

Q. Also, I was wondering, to the best of your knowledge whether a referee, a medical referee as called for under section twenty-two, one has ever been used in an asbestos case?

25 A. Not to my knowledge, sir. I am not aware. That question, you would have to review all of the cases where this had been involved, and I...

Q. It's not something that springs to mind?

A. No, sir.

30 Q. The other thing that arises out of the

5 Q. (cont'd.) discussion I believe you had with Mr. Starkman, concerning the corporate board, and I guess it brings to mind some problems I sometimes have as far as the actual jurisdiction of an appeals adjudicator and/or an appeal board, in that what precisely are they guided by?

Obviously, I would hope they are guided by the Statute.

10 A. Yes.

Q. Now, is it also true that they are guided by Board policy? I should say we just had a very brief education on the differences between policies, directives and guidelines.

15 A. Yes, they would generally be looking at the Board policy. If they were going to depart from Board policy, they would be discussing that matter to determine what the departure is, do they feel that the policy is in error, should there be some change in the policy, and they would bring that to the attention of the registrar of appeals to request a review of the policy if they felt that they were...

20 Q. Before and after a decision was made?

A. It would depend on the individual circumstances. They may feel that the policy is clearly wrong, that the Statute is, of course, the final jurisdiction and they would be making a decision in accordance with the Statute.

25 Q. So to the best of your knowledge, an appeals adjudicator, let's say, would not necessarily be fettered by Board policy if it was clear to that particular adjudicator that the merit of the case was such that it should be allowed?

A. I have seen cases where the appeals adjudicator, to my mind, has not conformed with Board policy. That's correct.

30 Q. To the best of your knowledge, is there any mechanism in place for either an individual worker or a group of

Q. (cont'd.) workers through their union, or presumably employers, appealing an actual policy?

5 A. They can request a review of the policy.

As a matter of fact, very recently...well, not very recently, some time ago, a particular union asked us to examine the policy, and that was done.

10 Q. Maybe I can at this point follow up with Mr. Starkman's question to Dr. McCracken, and perhaps you can help us out as far as determining exposure as part of the adjudication process - determining exposure for nonfixed-site workers?

15 A. I think I went into this the other day and I attempted to indicate that where you have, for example, the man who is assigned to his work through a local union, we would contact the union and attempt to contact as many employers as possible, to identify where that individual had worked over his working career to try and establish exactly what that exposure was.

20 If any dust readings were available from any of those various sites, he would try and get it.

25 But in some of the jobs, it is most difficult. But you try and identify, as best you can, and it's surprising the number of individual workers who do retain their own records as to exactly where they have been employed over a period of time.

Q. Presumably, though, you might run into problems in say demolition workers or construction workers, where let's say they were on a job for six months and there was only a part of that time where they were directly exposed to asbestos.

I mean, it would seem to me to be a very complicated process.

30 A. Yes, it can be, and I suggested this, that what we would attempt to do is have our field investigator visit as many sites as he could, contact the unions, contact other workers who

5 A. (cont'd.) may have been at the same site. I guess that you would look at the situation that Dr. Dyer described in the gas mask situation - you went back and tried to get as much historical data as you could from any of the work sites that the individuals were at.

10 In his one example, it was one particular site more than any other, but this is the type of thing that you would have to do. You would have to go back and attempt to gather information as best you possibly can.

15 Q. Okay. The other question I have as far as interpreting the Statute goes, I notice under section one twenty-two, one, in the Act - which is the initial entitlement section for industrial disease - there is a qualification here that the person will be entitled:

"unless at the time of entering into the employment he has wilfully and falsely represented himself in writing as not having previously suffered from the disease".

20 I am just wondering if, to the best of your knowledge, that particular section has ever been applied, or that clause of that section?

A. I am not aware of that section ever having been applied.

Q. So it's not a big worry, as far as you know?

25 A. No, sir.

Q. Okay. I would like to turn now to the whole area of setting the pension and the permanent disability award, and we have discussed with Dr. McCracken and others the whole question of impairment versus disability, and we've looked at some of the Board policies and what not.

30 I just want to have it absolutely clear from all

5 Q. (cont'd.) sides that what we are dealing with here, and I'm wondering do you see there being any difference, in talking about asbestos-related cases and asbestosis in particular, in what the percentage figure that the ACOCD comes up with and the ultimate percentage that the individual worker is assigned by the claims adjudicator in AD and D?

10 A. Not under the provisions of forty-three, one, I wouldn't see any difference.

Q. So you see forty-three, one as meaning the clinical impairment?

A. Yes, sir.

Q. In which case the claims adjudicator would have virtually no independent role in setting that final figure?

15 A. He would have advice to the expert opinion that has been provided to him, and I would think he would generally follow the recommendations of the committee.

Q. Would the claims adjudicator have the authority to change a figure that came down from the ACOCD, or from Drs. Dyer or Stewart?

20 A. Does he have the authority?

Q. Yes.

A. Yes, he does. But I would think that he would generally be guided by the opinion that is there.

25 Q. Well, pardon me for being confused, but it's... I mean, it strikes me you are saying that your interpretation of forty-three, one is that that is designed specifically to estimate the clinical impairment?

A. Yes, sir.

30 Q. And we have heard that the people with the responsibility, if you like, of estimating the clinical impairment in the case of asbestosis, are the ACOCD?

A. Yes, sir.

5 Q. Now, I'm not exactly clear on how the adjudicator gets involved in that role.

A. They provide that opinion to the adjudicator, the same as in a trauma case - the pensions medical advisor will provide his opinion to the adjudicator. The adjudicator is not bound to accept that opinion.

10 He has the ultimate decision as to...

Q. But on what grounds would he change the opinion?

15 A. Well, I suggested to you that generally he would be following the opinion of the committee. He would be ill-advised to do otherwise. They are the experts providing him with this information.

20 Q. So I would take it that, from your answers, that as I understand the system in British Columbia, you would not see that as any kind of model in assigning permanent disability awards, which I understand it is that the clinical assessment is made, and then there is a separate assessment taking into account socioeconomic factors, which may or may not change that percentage...

A. I think that's where you get into section forty-three, five as far as our own section is...

25 Q. Well, we are getting to forty-three, five in a minute, but as I understand the British Columbia system...

A. I would like to have clarification of exactly what you are considering from British Columbia in that respect.

30 Q. Well, as I understand the British Columbia method of rating pensions, you would have an initial clinical assessment which gives you the clinical impairment, and then presumably the claims or pensions adjudicator will then take into

Q. (cont'd.) account the other factors, and not give necessarily a supplement, but may increase the award.

A. I guess what I would to do is see the opinion of, and the documentation regarding British Columbia.

Q. Unfortunately, I don't have that with me. I can certainly provide it for the Commission. I believe decision number nine, I believe it was, on the B.C. Reporter series initiated this.

I take it from your last appearance here that you had a chance to go through Professor Barth's report, and I can't remember if this came up, but have you had a chance to see Professor Eissen's critique of Professor Barth's report?

A. Yes, I have.

Q. I am just wondering, in particular Professor Eissen has, on pages ten, eleven and twelve of his...

A. I don't have Professor Eissen's report at this point in time. I read the report and...

Q. Well, in particular I am referring to a table that he drew, and I don't know if you remember that, but he classified under three columns the method of adjudicating claims for asbestos.

I am wondering if you have any comments on his critique in general, not dealing with specific numbers here, but...

A. In general I think that Professor Eissen was trying to have every adjudicator as a lawyer.

Q. As a lawyer?

A. Yes, sir.

Q. So you would see where he is saying nonmedical fact, that would be a legal...

A. Yes, sir.

Q. I would like to very briefly touch on the

5 Q. (cont'd.) area of pre-existing conditions, and I'm just wondering in setting the pension right, would that be something that a claims adjudicator would be involved in in any way, or again is that strictly a medical question - where you are setting a percentage amount? Is it strictly up to the medical people to determine what part of that disability or impairment, what part of that impairment is related to asbestos and what part may be related to other factors?

10 A. I think they would provide you with an opinion as to what portion of the individual's disability was related to what condition, but the adjudicator would eventually decide how much should be granted in a particular claim.

15 Q. But the medical people would have some say in it, at least initially?

A. It's pretty hard to divide percentage of disability on a pre-existing condition, because in most instances you don't have a measurement prior to the examination.

20 In other words, it's not as if the man had the arm off at the elbow before the accident, and then had it off at the shoulder after the accident. In any event, you would still take it as a shoulder amp, so I don't think it comes in very often.

25 Q. I'm just wondering in light of that, we heard from Dr. Gray that in his role at the AC OCD that he certainly wasn't aware, hadn't been notified of any policy that the Board has in pre-existing conditions, and I'm wondering - given the fact that they may be making recommendations on something that may or may not be part of the pre-existing condition policy of the Board where there has been any communication of these kind of policies to the AC OCD?

30 A. I am not familiar with Dr. Gray's testimony, so I really can't say, but I would suggest that they are giving their opinion of the individual as they find him at the time of

A. (cont'.d) the examination.

5 Q. So to the best of your knowledge there hasn't been communication between either yourself or others?

A. You mean personally with Dr. Gray?

Q. No, with the ACOCD as far as Board policies go?

10 A. I have had no communication with the ACOCD in that respect at all. Any communication with the ACOCD would be through the medical, sir.

Q. A couple of minutes ago you mentioned the area of supplements under section forty-three, five, and I have noted in Barth's report at page three, seventeen, two-thirds of the way down - it's just a brief sentence, so I'll read it out:

Barth says, quote:

15 "Why has the WCB not made greater use of section forty-three, five in such cases, and avoided the criticism it has received".

End quote.

Maybe I can just pass that question along to you.

20 I mean...

A. Yes, I responded to that particular question the other day, Mr. McCombie. I guess you were not here at the time.

25 I suggested that for the most part the individuals who were being examined and being granted a pension were still in the employment.

The Act was amended in 1974 to permit the payment of pensions where the individual remained in exposure, and in most of the instances the man was working, had no wage loss and therefore there was no supplement payable.

30 Q. But in cases where someone has been diagnosed and has a pension for asbestosis, and is not working, is there any

5 Q. (cont'd.) kind of specific guidelines or criteria that are used in applying section forty-three, five, or is it just the general...

A. The same general provisions of forty-three, five would apply whether it's an industrial disease or a trauma case.

10 Q. Okay, just one further question in this area. And again I'm not sure if this has been touched on very much, but I'm curious about the lines of communication between the Workmen's Compensation Board as such, and the Ministry of Labour, the occupational health and safety branch, and in particular in situations where in this case the Board becomes aware of a particular problem...what mechanism there is to ensure that there is followup on the part of the occupational health and safety branch.

15 A. Any contact, any primary contact in that area is through the medical services division, Mr. McCombie.

Q. That would be exclusively their function?

20 A. Well, we do have regular meetings with them, in which we participate, but the primary contact, the identification of a disease or of a problem, is usually through the medical area.

Q. So you wouldn't have any information on that?

25 A. No, I would suggest that it is medical, as I indicated.

Q. Well, we have five minutes, so very briefly I would like to touch on a couple of other areas.

30 We have discussed to some extent the proposed changes, the so-called White Paper on Workers' Compensation, and first of all I would just be curious to know whether or not either yourself or other people at the Board have in any way had a

Q. (cont'd.) role in preparing the White Paper,
as it now is.

A. In preparing the White Paper?

Q. Yes.

A. Certainly.

Q. Pardon?

A. Certainly.

Q. Okay.

I guess the reason I ask is, I am just wondering
how these changes are going to affect the adjudication of
asbestos-disease claims, and in particular whether you see the
situation changing as far as ...

A. How do you see the issue being addressed
in the White Paper as it relates to this? You are familiar with
Professor Weiler persuing industrial diseases specifically in
phase two, so...

Q. Yes.

A. ...maybe you could be more specific.

Q. The question of adjudication and awarding
compensation and awarding a percentage disability, and then the
question of the wage loss system as it set out in the White Paper,
and also the question...I'm just wondering how you see this thing
being administered in the wage loss system as envisaged by the
White Paper, and in particular where there is a wage loss that is
established due to asbestosis. I'm just curious.

A. I think you are being rather speculative, because
it is just that, a White Paper, and it is being presented to a
standing committee, and what will eventually come from the standing
committee may not be in any way related to what appears in the
current White Paper, and what additional things may flow from
Phase Two of Professor Weiler's report may be totally different
again.

5 Q. Well, leaving aside for a moment Professor Weiler's second report, and just dealing...I'm just interested in the claims adjudication aspect of this and how it is going to be administered, and it seems to me there may or may not be problems as it is currently proposed, and I'm sure the Commission would be interested to know how this change is going to affect the actual adjudication and administration.

A. I think you are...

10 Q. Okay.

A. ...you are ahead of...

Q. Well, given the fact that it's getting on and your time is just about up...

A. Well, I've got a few more minutes. Go ahead, whatever you want, I'll try and respond to.

15 Q. Okay. Well, am I understanding rightly that you don't want to discuss the White Paper proposals?

A. I don't see the White Paper being here at this point in time. I guess if you want specific questions about a section of the White Paper, I'll try my best to respond, but it is not my paper, it's Professor Weiler's paper, and there will have to be development of processes as to exactly how it is going to be administered.

20 Q. Accepting that it is a proposal, it's not legislation, it is nevertheless on the table, and accepting the fact that you have indicated that there was a role by the Board in preparing it, and assuming that these kind of questions have been looked into by the Board as far as administration...I mean, I looked at the proposals under the White Paper for changing the system of awarding permanent disability payments, and I wonder how this is going to be administered..whether someone that is recognized as being asbestotic and is receiving a wage loss supplement, whether they were going to be reviewed every year or

25

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Q. (cont'd.) how it's going to work.

As we have heard, right now the person is seen by the ACOD, they are given a percentage amount, and then they may or may not receive a supplement, they may or may not go back to work. I mean, I think it's fairly straight forward and I'm just wondering how that is going to change and whether it is going to be easier or harder to administer.

A. Well, on the basis of what I see there, if the individual has a permanent disability assessment and continues in the employment with no wage loss, I don't see how he would qualify for payments under the wage loss scheme.

Q. Right. And if that person, as happened at Johns-Manville when the transite pipe section closed down, is then out of work, and we have heard that people that have an asbestotic condition feel that it's very difficult to get jobs elsewhere, I'm just wondering if that is going to be the kind of thing that will be taken into consideration.

A. If it can be shown that his disability is contributing to his...

Q. Unemployment?

A. ...unemployment, then he would be considered for wage loss.

That would be my interpretation of it, sir.

Q. Do you have any idea how, say, deterioration - and we certainly have heard an awful lot about the progressive nature of asbestosis, and in the present circumstances we have someone that is ten percent disabled, and then a year later they may be rated again and determined to be twenty percent disabled.

A. I wouldn't see the process changing. I think there would be a recommendation for continuing re-examination of those individuals, Mr. McCombie.

Q. And if they were...if the rating assessment

Q. (cont'd.) was increased, then they would just get...

A. It would be recognized, yes, sir.

Q. ...another lump sum based on that...

A. I would anticipate that, yes.

MR. McCOMBIE: Okay. I've given--

THE WITNESS: You know, have you got much more to go? Fine, if you...

MR. McCOMBIE: Yes, I have quite a bit and I don't want to sort of get into a whole area and then be caught short suddenly, so...I'm fine.

THE WITNESS: You've got another ten minutes. Is that of any value to you?

DR. DUPRE: You are being offered a plum here, Mr. McCombie. If you want another ten minutes, the witness will grant you...

MR. McCOMBIE: Well, I appreciate that, Mr. Chairman.

DR. DUPRE: I will say something..I won't impose on his good will beyond that additional ten minutes he has just granted, so...

Thank you, Mr. McDonald.

MR. McCOMBIE: Q. Okay. Well, maybe I can go back to some of the other areas.

We heard from Dr. Pelmear, I believe it was, that there would occasionally...that the occupational chest disease service would occasionally have a three-party consultation concerning a particular individual, and as he explained it, these three parties would be someone from the occupational chest disease service, the examining or company physician from the workplace involved, and a WCB representative.

Are you aware of these consultations at all?

THE WITNESS: A. No, I'm not familiar with that process at all, sir. Where was he suggesting...like...

Q. Pardon?

A. Did he indicate what branch the person would be from, from the WCB?

Q. I believe he indicated it was from the medical branch. I believe it was Dr. Stewart.

I'm just wondering from the claims point of view...I gathered from his and other testimony that there is an awful lot of information that flows either through these kind of conferences or files, between the...in particular the chest disease section at the ministry and the WCB...and I'm just wondering if that is only at the level of the medical section, or whether that gets involved in the claims adjudication at all.

A. We do have a representative attend some meetings with Dr. Pelmear. I think it's on a quarterly basis, but it's a general discussion-type situation, rather than any specific cases. Any discussion that Dr. Pelmear is talking about there I guess would normally involve the medical services division.

Q. He also indicated that he would notify the WCB...this is through the chest disease section...of any abnormalities that were found on the x-rays during the medical monitoring, the mobile x-ray unit?

A. Yes, sir.

Q. I'm wondering if, again, that would be something that claims would be involved in or if that would stay strictly in the medical...

A. When the claim is established...I think I mentioned the other day in my testimony that I am aware of three cases, three claims that were established for this year as a result of a medical survey program, and those claims, when they are established they are referred to the claims services

A. (cont'd.) division for consideration.

Q. But if there were abnormalities, yet ones which have been in what we have been describing as the grey area, they wouldn't necessarily come to your attention, or would they?

A. We wouldn't receive them until such time as they were established as a claim, Mr. McCombie.

Q. We were talking this morning about the guidelines that were established for various diseases, and we were asking Dr. McCracken his opinions on Dr. Barth's...or Professor Barth's observations as far as public input into setting of those guidelines, and I'm wondering if we could very briefly have your views on the...

A. Yes, I gave them the other day, as a matter of fact, Mr. McCombie, and I think if you could find the individuals in the public with the appropriate expertise that had something that could be offered in that area, it could be of assistance. But I'm not quite sure where that expertise comes from.

Q. Well, the suggestion was made, or was put forward by the Chairman, for example that there could be some kind of post hoc examination of the guidelines and as an example, through one of the committees of the Legislature.

I'm wondering if you would have any views on that - either the standing committee on resource development or some other particular committee?

A. I guess I'm not sure of their expertise in the particular area, Mr. McCombie.

Q. So you would feel that there would need to be a particular expertise before ...I mean, there couldn't be just a ...

A. The other day when we were talking about it, Dr. Uffen suggested the possibility of having the CMA...not

5 A. (cont'd.) Canadian Manufacturers' Association, but Canadian Medical Association - at least that's the way I interpreted his comment - develop these guidelines.

I'm not sure that they necessarily have the expertise that you could draw, that they would be prepared to devote the time and the research to develop them, and sure...I don't think you can come onto it blind. I think that you have some knowledge of the subject in order to contribute.

10 Sure, I think that any opinion, any input that you can get is fine, but it should have some support, some basic reason - not say, hey I don't like ten years.

You have to have some rationale for making the change. You just don't...

15 Q. Would you necessarily be opposed to appearing before such a Legislative committee and explaining 'this is how we arrived at this and these are the people that were involved in arriving at this particular number in this particular guideline'?

I think that that is more the question, rather than...

20 A. I don't think I would have any choice. If the committee wanted me to be there, I would be there.

Q. That's a point well taken, but do you have a personal opinion on it?

25 I mean, did you see any value in that? I guess that's what I'm trying to get at. I mean, there has been some suggestion in Barth and elsewhere that this is a somewhat closed system, and just the appearance of this kind of input would certainly be helpful.

30 A. Sure. I have no problem with some public input, if you will, to the guidelines, and I guess I'm not sure exactly where that public input would come from. I think that some expertise is required.

A. (cont'd.) To offer an explanation of the guidelines? I'm quite prepared to do that.

But whether the explanation of the guidelines to a committee is necessarily going to change the perception of the guidelines as being satisfactory, I don't know.

Q. Can you, just very brief question, tell us when it was that the Board's manuals, the adjudication manuals, were first made available to the public?

A. I can't...

Q. Which would contain these guidelines?

A. I can't give you a specific date, Mr. McCombie.

Q. Roughly? I mean is it two years ago, three years ago?

Okay, well, maybe...

A. I would say it would be approximately three years ago, but I'm not sure. But the guidelines themselves were available before that, but the general package of the Board's manuals was subsequent to that. But individual guidelines were available before that time.

Q. Yes. We did talk to Dr. McCracken about this, and maybe I can just have a quick followup on that conversation, and he indicated that they were available, in fact, before the publication of the manuals.

But as was pointed out, it wasn't something that was generally known, and I'm just wondering, like, how widely available were they? I mean, if I came in, as a worker from plant X, and had an asbestos claim, would I have been at that point or even now directed to the policy that dealt with that particular thing?

A. I don't think an individual worker would be involved in very many like that, but I think what would normally happen, his representative or his union generally would have

5 A. (cont'd.) been aware of the guidelines, the existence of the guidelines, and would have had copies of those guidelines.

MR. McCOMBIE: Your ten minutes is up, my ten minutes is up. I thank you for your patience.

DR. DUPRE: My third opportunity to thank you, Mr. McDonald, and I do so with a greater degree of warmth each time.

10 Thank you, indeed.

The Commission now rises until the month of August, which the Commission intends to be its final month of hearings, and we rise until, as I understand it, the 10th of August, which is a Tuesday, at ten a.m.

15 Thank you very much.

20 THE INQUIRY ADJOURNED

25 THE FOREGOING WAS PREPARED
FROM THE TAPED RECORDINGS
OF THE INQUIRY PROCEEDINGS

Edwina Macht
30 EDWINA MACHT

